

0916038

CERTIFICATE OF DEATH

Reg. Dist. No.

9173

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3110 Texas Avenue</u>				d. STREET ADDRESS <u>3110 Texas Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Frederick Walter</u> First Middle Last <u>Amorose, SR.</u>				4. DATE OF DEATH <u>Sept. 23,</u> 19 <u>57</u> Month Day Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 27, 1900</u>	
				9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookbinder</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Louis Amorose</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT Address <u>Mrs. Lillian J. Amorose,</u> <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Left hemiplegia.</u> DUE TO (c) <u>Cerebral Embolism.</u> INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u> <u>June 4, 1957</u> <u>June 4th</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 23, 1957</u> to <u>Sept 23, 1957</u> that I last saw the deceased alive on <u>Sept 23, 1957</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James E. White</u> M.D.				ADDRESS (Street, city or town, state) <u>5214 Harford Road</u> DATE SIGNED <u>9/23/57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. James E. White</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9-26-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balt MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road</u>				24a. REC'D BY REGISTRAR <u>SEP 25 1957</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Bacon</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
 SEP 25 1957
 BUREAU V. S.

NAME OF DECEASED [Faint, illegible text]		SEX [Faint, illegible text]	
AGE [Faint, illegible text]		DATE OF BIRTH [Faint, illegible text]	
PLACE OF BIRTH [Faint, illegible text]		PLACE OF DEATH [Faint, illegible text]	
OCCUPATION [Faint, illegible text]		CAUSE OF DEATH [Faint, illegible text]	
MANNER OF DEATH [Faint, illegible text]		TIME OF DEATH [Faint, illegible text]	
SIGNATURE OF DECEASED [Faint, illegible text]		SIGNATURE OF WITNESSES [Faint, illegible text]	
SIGNATURE OF PHYSICIAN [Faint, illegible text]		SIGNATURE OF CORONER [Faint, illegible text]	

9174 CERTIFICATE OF DEATH

Reg. Dist. No. 39

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Phoenix</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Phoenix</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Stockton Road</i>		d. STREET ADDRESS <i>Stockton Road</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Agnes L. Amos</i>		4. DATE OF DEATH <i>September 29th 1957</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 10, 1885</i>
9. AGE (In years lost birthday) <i>72</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Oswald Schulz</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Kiel, Stockton Rd. Phoenix</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept 21st 1957</i> , to <i>Sept 29th 1957</i> , that I last saw the deceased alive on <i>Sept 28th 1957</i> , and that death occurred at <i>10:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>M. K. Quinn</i> M.D.		ADDRESS (Street, city or town, state) <i>York Road</i> DATE SIGNED <i>9/30/57</i>	
PHYSICIAN'S NAME (Type) <i>Dr. Kevin Quinn</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/2/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR <i>DATE 10-2-57</i>	24b. REGISTRAR'S SIGNATURE <i>Elizabeth Horsuch E.J.</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

2 OCT 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9175

CERTIFICATE OF DEATH

09162

Reg. Dist. No. 33

1. PLACE OF DEATH <i>Rosewood State Training School</i> a. COUNTY <i>Baltimore Co. Owings Mills</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George Co.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>141/10ma</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C. 16x2.2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <i>Rosewood State Training School</i>				d. STREET ADDRESS <i>3325 - 81st Ave. S.E.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <i>Charles Flagg Anderson</i>		4. DATE OF DEATH Month Day Year <i>9 22 1957</i>					
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/17/51</i>	9. AGE (In years lost birthday) <i>5 yrs.</i>	IF UNDER 1 YEAR Months Days Hours Min. <i>11 5</i>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Crawford Anderson</i>				14. MOTHER'S MAIDEN NAME <i>Flagg</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NO</i>		17. INFORMANT <i>Rosewood Record</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration pneumonia</i> 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>cerebral spastic paralysis</i> DUE TO (c) <i>malnutrition and epilepsy</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov 15</i> , 19 <i>55</i> to <i>Sept 22</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Sept 21</i> , 19 <i>57</i> , and that death occurred at <i>3:40 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Olive Reid Harris, M.D.</i>				ADDRESS (Street, city or town, state) <i>Rosewood St. S. School</i>		DATE SIGNED <i>9/22/57</i>	
PHYSICIAN'S NAME (Type) <i>Olive Reid Harris, M.D.</i>				<i>Owings Mills, Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>Sept 25-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Hillside</i>		22d. LOCATION (City, town, or county) (State) <i>Eastport, Maine</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank H. Nance, Baltimore, Md</i>				24. REC'D BY REGISTRAR <i>DATE 3 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Mary Edine</i>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Usual residence		7. Date of death		8. Place of death		9. Cause of death		10. Manner of death		11. Signature of physician		12. Signature of registrar	

9176

CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ashwood</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u> x2 <u>Overleg.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street, address) OR INSTITUTION <u>14 Behind Ave</u>		d. STREET ADDRESS <u>14 Belinda Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>J.</u> Last <u>Andrews</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 18 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>17</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Kurana</u>		14. MOTHER'S MAIDEN NAME <u>Josephine</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Stanley Andrews</u>		Address <u>14 Belinda Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>3 yrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/19</u> , 19 <u>57</u> , to <u>9/17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/17</u> , 19 <u>57</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1 W. Overlea Ave.</u> DATE SIGNED <u>9-17-57</u>			
ACTUAL SIGNATURE <u>Zsigmund John Toth</u> M.D.		22. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER CEM.</u>	
PHYSICIAN'S NAME (Type) <u>Zsigmund John Toth, M.D.</u>		22d. LOCATION (City, town, or county) (State) <u>4430 BELAIR RD MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT 19-57</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Duffel Bros</u>		24a. REC'D BY REGISTRAR <u>SEP 18 1957</u>	
ADDRESS <u>7110 BELAIR ROAD</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. L. L. Rappaport</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAKING STATE DEPARTMENT OF HEALTH-BALTIMORE

BUREAU V. R.

SEP 18 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Baltimore, Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> X 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1511 Taylor Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>A. (Albert)</u> Last <u>Bailey</u>				4. DATE OF DEATH Month <u>9</u> - Day <u>25</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/28/1888</u>		9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber - Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
13. FATHER'S NAME <u>Charles Bailey</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Elsie E. Bailey, 1511 Taylor Ave. Parkville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concussion of Esophagus</u> <u>150x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-19-1957</u> , to <u>9-25-1957</u> , that I last saw the deceased alive on <u>9-25-1957</u> , and that death occurred at <u>12:30 M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4508 Harford Rd.</u> DATE SIGNED <u>9-25-57</u> ACTUAL SIGNATURE <u>C. W. Peake</u> M.D. <u>4508 Harford Rd. Balto. Md.</u> PHYSICIAN'S NAME (Type) <u>Dr. C. W. Peake</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, Inc</u>				ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 27 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. M. L. Lacey</u>			

1358

71001168

Charles Heller

State Z. Taylor, 1211 Taylor Ave., Parkville

BUREAU V. S.

SEP 27 1957

RECEIVED

Dr. C. W. Feltus

Downloaded At: 11:53 11 September 2009

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b 53 Dundalk			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8210 Dundalk Avenue				d. STREET ADDRESS 1 8210 Dundalk Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CLEDA Middle H Last BARNWELL				4. DATE OF DEATH Month Sept. Day 12 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 25, 1902		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months 5 Days 12	IF UNDER 24 HRS. Hours 19 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsavyvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT John D. Barnwell 8210 Dundalk Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Colmar Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension C-V-Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.	Month, Day, Year 19 57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. Davis M.D.		DATE SIGNED 9/15/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 16, 1957		22c. NAME OF CEMETERY OR CREMATORY Loundon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home, Dundalk, Md.				24a. REC'D BY REGISTRAR SEP 17 1957			
				24b. REGISTRAR'S SIGNATURE Jm. Kelly			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Report		Time of Report		Place of Report	

RECEIVED
SEP 18 1957
BUREAU V. S.

RECEIVED
SEP 18 1957
BUREAU V. S.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9154

CERTIFICATE OF DEATH

09166

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverview				c. LENGTH OF STAY IN 1b 2 yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Riverview							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 920 Winsap Court				d. STREET ADDRESS 920 Winsap Court			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Margaret Middle V. Last Beares				4. DATE OF DEATH Month Sept. Day 21 Year 19 57			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1885		9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.		11. BIRTHPLACE (State or foreign country) Balto.Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Vinyard				14. MOTHER'S MAIDEN NAME Ida -----			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address #27, MD. Mr. Raymond Beares, 3103 Bero Rd, Lansdown			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro - Vascular Acc 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive C-V. Disease DUE TO (c) 390 INTERVAL BETWEEN ONSET AND DEATH 4 wks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 46 , 19 57 , to Sept 21 , 19 57 , that I last saw the deceased alive on Sept 21 , 19 57 , and that death occurred at 12:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund S. Kallins M.D. 4300 W. 10th St				DATE SIGNED 9/23/57			
PHYSICIAN'S NAME (Type) EDWARD S. KALLINS MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sep. 24/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Balto.Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave				24a. REC'D BY REGISTRAR SEP 24 1957		24b. REGISTRAR'S SIGNATURE Tom Kelly	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

SEP 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9178

CERTIFICATE OF DEATH

09167

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>52</u> <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shady Nook Nursing Home</u>				d. STREET ADDRESS <u>409 S. Rolling Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>E.</u> Last <u>Boguess</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 5, 1871</u>		9. AGE (In years last birthday) <u>85</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James H. Blue</u>				14. MOTHER'S MAIDEN NAME <u>Phoebe Bloomer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT Address <u>Mrs. Miriam Kern 409 S. Rolling Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs +</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Sept 2</u> , 19 <u>55</u> , to <u>Sept 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 9</u> , 19 <u>57</u> , and that death occurred at <u>7:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John A. Nesbitt, Jr.</u> M.D. <u>1112 St Paul St.</u>							
PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, JR.</u>				<u>Baltimore 2, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Sept. 10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mentone Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mentone Indiana</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home Catonsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 13 57</u>		24b. REGISTRAR'S SIGNATURE <u>Quincy</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

SEP 13 1957

RECEIVED

9179

CERTIFICATE OF DEATH

Items 14 & 7 G221 10/15/57 GL

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 607 Seabrook Rd.				d. STREET ADDRESS 607 Seabrook Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle ROSE Last BOLAND		4. DATE OF DEATH Month Sept. Day 15 Year 19 57					
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1880	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) London, England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick Sullivan				14. MOTHER'S MAIDEN NAME Margaret Daly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Lawrence A. Kraff - 607 Seabrook Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 15, 1957 , to Sept 15, 1957 , that I last saw the deceased alive on Sept 15, 1957 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Frederick J. Vollmer		M.D. 6100 York Rd, Balt-12		DATE SIGNED Sept 16, 1957			
PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/57		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichenor & Sons - Balt-17				24a. REC'D BY REGISTRAR DATE 18 1957		24b. REGISTRAR'S SIGNATURE Mark Guye	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09169 41

Reg. Dist. No.

9155

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b 35 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 28 Kinship Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First William Middle Porter Last Bosley				4. DATE OF DEATH Month September Day 7 Year 1957			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19, 1894	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance				10b. KIND OF BUSINESS OR INDUSTRY Steel Man		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Bosley				14. MOTHER'S MAIDEN NAME Susan Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. WW I 213-07-4264		17. INFORMANT Oscar Staats Address 6932 Broening Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Heart							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M.B. Davis M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M.B. DAVIS M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10 Sept. 1957		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Balto. Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley Inc. Dundalk				24a. REC'D BY REGISTRAR SEP 11 1957		24b. REGISTRAR'S SIGNATURE Wm. P. Kelly	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

SEP 11 1957

RECEIVED

9180

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX 54</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>607 MACE AVE.</u>		d. STREET ADDRESS <u>607 MACE AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY FRANCES BOURNE</u>		4. DATE OF DEATH Month Day Year <u>SEPT. 5 19 57</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 8-1869</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VA.</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JAMES MORRIS</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>WM. E. BOURNE</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Schenck Generalized</u> DUE TO <u>Cardia - Vascular Renal Dis</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Thrombosis - Arteriosclerosis & Hemiplegia</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 15, 19 57</u> , to <u>Sept 5, 19 57</u> , that I last saw the deceased alive on <u>Sept 5, 19 57</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John D. Connelly</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>3001 Flamingo Drive Baltimore, Md</u> <u>SEP 9 1957</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	22b. DATE THEREOF <u>SEPT. 6-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BEAVER DAM</u>	22d. LOCATION (City, town, or county) (State) <u>FLOVANNA VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Connelly</u>		ADDRESS <u>418 Eastern Ave. Baltimore, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Harley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 9 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

9181

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b one month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines				d. STREET ADDRESS 528 Yale Avenue			
3. NAME OF DECEASED (Type or print) First Mollie Middle Ellen Last Bowen				4. DATE OF DEATH Month Sept. Day 22, Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 22, 1889	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Edward Platt				14. MOTHER'S MAIDEN NAME Ida DeUnger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Clifton Bowen 444 Random Rd., Baltimore, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1. Gangrene toes 2. Abscess left hip							
INTERVAL BETWEEN ONSET AND DEATH 12 hrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from February, 1957 , to 22 September, 1957 , that I last saw the deceased alive on 21 September, 1957 , and that death occurred at 2 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James E. Rowe				ADDRESS (Street, city or town, state) 715 Frederick Road, Catonsville 28, Md			
DATE SIGNED September 24, 1957							
PHYSICIAN'S NAME (Type) James E. Rowe							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 24, 1957		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Easton Rowe				ADDRESS Catonsville, Md.		24a. REC'D BY REGISTRAR SEP 26 '57	
				24b. REGISTRAR'S SIGNATURE Al. Lewis			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

SEP 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9182

CERTIFICATE OF DEATH

Reg. Dist. No. 0917244

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 32 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2707 W. North Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE --- BROWN				4. DATE OF DEATH Month Day Year September 18 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 31, 1908	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Buckingham County, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY Pool Room			
13. FATHER'S NAME Matt Brown				14. MOTHER'S MAIDEN NAME Janie Mosley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 218-05-0408		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE 600.0 DUE TO PYELONEPHRITIS CHRONIC Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 17 , 19 57 , to September , 19 57 , and that death occurred at 5:55A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 9/18/57 ACTUAL SIGNATURE Harold R. Johnson M.D. PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-20-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery, Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Mortuary, 802-04 Madison Ave., Balto I, Md.				24. REG'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Dawson L. Farber			

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SEP 20 1957
BUREAU V. S.

SEP 20 1957

0917331

Item 2, Film 4221, 10/4/57

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gwyn Oak		c. LENGTH OF STAY IN Yr 3 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore/Md. 1556-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Augsburg Home		d. STREET ADDRESS 2406 Lindell St Silver Spring		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary R. Brown		First Middle Last		4. DATE OF DEATH Month Day Year September 28, 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 28, 1878		9. AGE (In years last birthday) 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Balto Co.	
13. FATHER'S NAME John Williamson Roe		14. MOTHER'S MAIDEN NAME Amanda Hooper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Records Augsburg Home 6811 Campfield Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) cerebral thrombosis 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) - Diabetes Mellitus DUE TO (c) -					INTERVAL BETWEEN ONSET AND DEATH 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (1) - Varicose Ulcer of leg -					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from -8/12- 19 54 , to Sept 28 19 57 , that I last saw the deceased alive on Sept 28 19 57 , and that death occurred at 10:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4108 Liberty Hts. Balto. DATE SIGNED 9-30-57					
ACTUAL SIGNATURE Earl L. Chambers		M.D. 4108 Liberty Hts. Balto - 9-30-57			
PHYSICIAN'S NAME (Type) Earl L. Chambers -		4108 Liberty Hts. Balto - 9-30-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sep. 30 57	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		22d. LOCATION (City, town, or county) (State) Balto Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul A. Heemann		ADDRESS 6067 Harford Rd.		24. REG'D BY REGISTRAR DATE Dr. Jm. Martney	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

INVESTIGATION OF DEATH—BATHING, 10

BUREAU V. 3

CT 1 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09174

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Belvoir 83X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		d. STREET ADDRESS Graveshill Trailer Camp	
3. NAME OF DECEASED (Type or print) First GORDON Middle W. Last BROWNE Sr		4. DATE OF DEATH Month September Day 12 Year 19 57	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec 26 - 1894
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist		10b. KIND OF BUSINESS OR INDUSTRY Pharmaceuticals	
11. BIRTHPLACE (State or foreign country) Kentucky, Louisville		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 049-12-2583	
17. INFORMANT Russell W. Browne Jr.		Address U.S. Army	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic and hypertensive cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Russell S. Fisher		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/13/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Sept 26 - 57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem		22d. LOCATION (City, town, or county) (State) Colman Heights, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William H. McDonald		24a. REGISTERED SEP 19 57	
ADDRESS Baltimore, Md		24b. REGISTRAR'S SIGNATURE W. H. McDonald	

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 19 1957

RECEIVED

[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09175

9185

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN IB 13 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Baltimore 7 d. STREET ADDRESS 3717 Croyden Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JACOB Middle S. Last BUCHER		4. DATE OF DEATH Month September Day 30 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1900
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Typewriter Repairs	
11. BIRTHPLACE (State or foreign country) Rexmont, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jonas Bucher		14. MOTHER'S MAIDEN NAME Olivia Snyder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Peace Time		16. SOCIAL SECURITY NO. 219-10-5639	
17. INFORMANT Clin. Rec., Vet. Administration, Ft. Howard Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154x CARCINOMA OF RECTUM WITH METASTASES TO LIVER AND ABDOMINAL LYMPH NODES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UNKNOWN DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation: Right transverse colostomy - 9/19/57			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 17, 1957 , to September 30, 1957 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VA HOSPITAL, FT. HOWARD, MD. DATE SIGNED 9/30/57			
ACTUAL SIGNATURE Chien Wei Lan		M.D. VA HOSPITAL, FT. HOWARD, MD.	
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-3-57	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell		24. REG'D BY REGISTRAR 1957	
ADDRESS Frank Newell Funeral Home, Reisterstown Rd., Pikesville, Maryland		24b. REGISTRAR'S SIGNATURE D. L. Farber	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BOSTON, MASS.

BUREAU V. S.

OCT 3 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9186

CERTIFICATE OF DEATH

09176 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard,				c. LENGTH OF STAY IN IB 38 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 Vol-4			
f. STREET ADDRESS 5203 St. Georges Avenue				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle O. Last BUTTOLPH				4. DATE OF DEATH Month September Day 30 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 26, 1890	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Floor Finisher				10b. KIND OF BUSINESS OR INDUSTRY Bowling Alley		11. BIRTHPLACE (State or foreign country) Potsdam, New York	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Austin Buttolph				14. MOTHER'S MAIDEN NAME Nina Stearns			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. 096-05-3823		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF COMMON BILE DUCT WITH METASTASES TO 155X REGIONAL LYMPH NODES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obstructive Jaundice due to (a) Operation - Exploratory Laparotomy - 9/17/57				INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from August 23, 1957 to September 30, 1957 and that death occurred at 10:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VA HOSPITAL, FORT HOWARD, MARYLAND DATE SIGNED 9/30/57							
ACTUAL SIGNATURE Chien Wei Lan				M.D. VA HOSPITAL, FORT HOWARD, MARYLAND			
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-3-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc. St. Paul & Preston Sts., Balto, Md.				24a. REC'D BY REGISTRAR OCT 2 1957			
24b. REGISTRAR'S SIGNATURE L. Shiley							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Form with multiple sections for recording death information, including fields for name, date, and cause of death. The text is mirrored and difficult to read.

RECEIVED
OCT 2 1957
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9187

CERTIFICATE OF DEATH

09177
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shady Nook Nursing Home</u>				d. STREET ADDRESS <u>11 S. Beechwood Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>V.</u> Last <u>Carter</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 18, 1877</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Bishop</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Lighthouser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>---</u>		17. INFORMANT Address <u>Calvin Carter 1502 Ivanhoe Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Probable Kaposi's sarcoma of skin</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-7-55</u> , 19 <u>55</u> , to <u>9-21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-20</u> , 19 <u>57</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John A. Nesbitt Jr.</u>				ADDRESS (Street, city or town, state) <u>1118 St Paul St.</u>			
PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, JR.</u>				DATE SIGNED <u>Baltimore 2, Ind</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-24-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home Catonsville Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 25 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>Dee L. Smith</u>			

BUREAU V. S.

SEP 25 1957

RECEIVED

9188

CERTIFICATE OF DEATH

09178
Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 72 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 604 Alvin Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ida Middle Rena Last Clark				4. DATE OF DEATH Month Sept. Day 30 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 7, 1885	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Henry Grine				14. MOTHER'S MAIDEN NAME Alverta Skidmore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address 28, Md. Mrs. Margaret Payne 605 Alvin Ave. Catonsville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-Vascular Disease DUE TO INTERVAL BETWEEN ONSET AND DEATH 5 years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 240X Diabetes Mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 10, 1950 to Sept 30, 1957 , that I last saw the deceased alive on Sept 28, 1957 , and that death occurred at 2 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William F. Lassaway M.D.				ADDRESS (Street, city or town, state) Ellicott City, Md. DATE SIGNED 9/30/57			
PHYSICIAN'S NAME (Type) WILLIAM F. LASSAWAY M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/3/1957		22c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		22d. LOCATION (City, town, or county) (State) Ellicott City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Carlton Stone				ADDRESS Catonsville, Md.		24a. REC'D BY REGISTRAR W. F. Lassaway	
				DATE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09179

9189

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 18 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 4418 Old York Road			
3. NAME OF DECEASED (Type or print) First HUGH Middle C Last CLOWER				4. DATE OF DEATH Month September Day 29 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 1, 1874	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) Wheatfield, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Clower				14. MOTHER'S MAIDEN NAME Francis MN: Unknown.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. SAW 216-05-0827		17. INFORMANT Address Clin Rec, Vet Adm Hosp. Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH WITH METASTASIS TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. LUNGS, LIVER AND ABDOMINAL LYMPH NODES. DUE TO UNKNOWN (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Arlington, Va.		(County) (State)	
21. I certify that VA attended the deceased from Sept. 11 , 19 57 , to Sept. 29 , 19 57 . XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXX and that death occurred at 2:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Veterans Administration Hospital 9/29/57 ACTUAL SIGNATURE Chien Wei Lan M.D. Veterans Administration Hospital 9/29/57 PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D. Fort Howard, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 10/29/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner 17, Md.				24a. REC'D BY REGISTRAR DATE 9/30/57		24b. REGISTRAR'S SIGNATURE Dawson L. Farber	

Ives Funeral Home, Wilson Blvd. Arlington, Va.

CERTIFICATE OF DEATH

Form with fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and other details. The text is mostly illegible due to the quality of the scan.

BUREAU V. A.

RECEIVED

OCT 1 1957

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES OF AMERICA	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		SPECIAL OCCUPATION		MILITARY SERVICE	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		LABORER		NONE		NONE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY	
APR 4 1968		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES OF AMERICA		SHOOTING		SUICIDE		GUNSHOT WOUND OF THE CHEST	
TIME OF DEATH		HOURS		MINUTES		SECOND		P.M.		TEMPERATURE		PULSE		RESPIRATION	
11:57		4		57		00		11		98.6		60		16	
ATTENDING PHYSICIAN		FAMILY PHYSICIAN		PATHOLOGIST		FORENSIC PATHOLOGIST		CORONER		MEDICAL EXAMINER		JURY		JUDGE	
DR. JAMES H. HARRIS		DR. JAMES H. HARRIS		DR. JAMES H. HARRIS		DR. JAMES H. HARRIS		DR. JAMES H. HARRIS		DR. JAMES H. HARRIS		DR. JAMES H. HARRIS		DR. JAMES H. HARRIS	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
DATE OF FILING		PLACE OF FILING		CITY OF FILING		STATE OF FILING		COUNTRY OF FILING		FILING OFFICE		FILING OFFICE		FILING OFFICE	
APR 10 1968		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES OF AMERICA		HEALTH DEPARTMENT		HEALTH DEPARTMENT		HEALTH DEPARTMENT	

BUREAU V. 8

OCT 1 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Item 2. State Police. Item 6 Film G221 10-21-57 et											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
9191 Item 9, Block 22, Film G221 10-16-57 et Reg. Dist. 09181											
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Dania</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PHILADELPHIA</u>				c. LENGTH OF STAY IN 1b <u>0</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>48X 3</u> ✓			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1304 Sta. A.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MANUEL</u> Middle <u>PAGO</u> Last <u>COLON</u>				4. DATE OF DEATH Sept. 28 1957							
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unknown</u>		9. AGE (In years last birthday) <u>43 ?</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>				11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>816X Multiple Fractures & Crushing</u> DUE TO (b) <u>Body Injuries</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>0</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Accident</u>							
20c. TIME OF INJURY Month, Day, Year <u>12</u> <u>9/28</u> 1957				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt 111</u>		20f. (City or town) <u>Parkton, Balto</u> (County) <u>MD</u> (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>G.M. France</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>9/28/57</u>			
EXAMINER'S NAME (Type) <u>A.M.F. FRANCE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>10-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>				22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS				24a. REC'D BY REGISTRAR <u>10/1/57</u>		24b. REGISTRAR'S SIGNATURE <u>Chester L. Fuller</u>	

1304 Sta A
Danea, Ha

BUREAU V. S.

OCT 2 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

Item 2 State of MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
9192 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Block 22 FilmG221 10-15-57 et									
Reg. Dist. No. 091825									
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Florida</u> COUNTY <u>Dania</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKTON</u>			c. LENGTH OF STAY IN 1b <u>NOV 2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dania</u> <u>48X 3</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <u>238 N.W. 7th</u>				
3. NAME OF DECEASED (Type or print) First <u>SIXTO</u> Middle <u>PAGO</u> Last <u>COLON</u>					4. DATE OF DEATH Month <u>SEPT.</u> Day <u>28</u> Year <u>1957</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <u>29</u> yrs.	
								IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>			11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u></u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE FRACTURES + CRUSHING BODY</u> 816X DUE TO (b) <u>INJURIES</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>0</u>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>AUTO MOBILE ACCIDENT</u>						
20c. TIME OF INJURY Month, Day, Year <u>12 30 a.m. 9/28 1957</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RT. 111</u>		20f. (City or town) <u>PARKTON BALTO. MD</u> (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>G. M. France</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF <u>10-15-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS					24a. REC'D BY REGISTRAR <u>10/1/57</u>		24b. REGISTRAR'S SIGNATURE <u>Chester L. Fultz</u>		

238 - N.W. 7th Ave.
Dania, Fla

BUREAU V. S.

OCT 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9193

CERTIFICATE OF DEATH

09183

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anneslie (Baltimore 12)	
3. NAME OF DECEASED (Type or print) First JOHN Middle D Last COSTLOW		4. DATE OF DEATH Month September Day 12, Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1983
9. AGE (In years last birthday) 24 1/2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Costlow		14. MOTHER'S MAIDEN NAME Catherine Sweeney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 7	
17. INFORMANT Mrs. John D. Costlow, 519 Dunkirk Rd., Balto., Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Hypertension DUE TO Cerebral Hemorrhage 4 yrs ago - cerebrovascular PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH Gradual	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 45 , to Present 9/12/57 , that I last saw the deceased alive on Sept. 12 , 19 57 , and that death occurred at 7:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1403 Park Ave Balto Md DATE SIGNED ACTUAL SIGNATURE W H Brady M.D. PHYSICIAN'S NAME (Type) John Burne Somers			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Sept. 14, 1957	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burne Somers		24a. REC'D BY REGISTRAR Sept. 13, 1957	
ADDRESS Towson, Md.		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John P. Doe		Male		45		Jan 1, 1912		New York, N.Y.	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Catholic	
Date of Death		Time of Death		Place of Death		Physician		Burial Place	
Jan 15, 1957		10:30 AM		Home		Dr. J. Smith		St. Mary's Church	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 1

SEP 16 1957

RECEIVED

John P. Doe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film G221 10-8-57 et

9156

CERTIFICATE OF DEATH

09184

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. LENGTH OF STAY IN 1b <u>53</u> <u>DUNDALK</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>126 VENTNOR TERRACE</u>				d. STREET ADDRESS <u>126 VENTNOR TERRACE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Louvenia</u> First <u>King</u> Middle <u>CROMER</u> Last				4. DATE OF DEATH Month <u>9</u> Day <u>30</u> Year <u>1957</u>									
5. SEX <u>FEM</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 26-1898</u>		9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George King</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Mason</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. GLADIS DEAN - 126 Ventnor Terrace</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Stomach.</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Hypertension.</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>10 years</u> <u>10 years</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u>													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>57</u> , to <u>Sept 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 28</u> , 19 <u>57</u> , and that death occurred at <u>5A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>33 Dundalk Ave</u> DATE SIGNED <u>9/30/57</u> ACTUAL SIGNATURE <u>David H. Andrew</u> M.D. <u>Dundalk 6217d</u> PHYSICIAN'S NAME (Type) <u>David H. Andrew</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10-2-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodbine Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Harrisonburg, Virginia</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lindey Funeral Home, Harrisonburg, Virginia</u> ADDRESS						24a. REC'D BY REGISTRAR <u>Oct 1 1957</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>					

1 OCT 1 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9194

CERTIFICATE OF DEATH

Reg. Dist. No.

09185

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2716 Frederick Road		d. STREET ADDRESS 2716 Frederick Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HOWARD M Middle CROSS Last		4. DATE OF DEATH Month Sept. Day 13 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-1880
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming-Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henson Cross		14. MOTHER'S MAIDEN NAME Mary Knight	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-10-7262	
17. INFORMANT Herman A. Miller, Catonsville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF STOMACH DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 Mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-9 , 19 57 , to 9-13 , 19 57 that I last saw the deceased alive on 9-13 , 19 57 , and that death occurred at 7:45 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Peter V. Thorpe M.D.		COLUMBIA RD	
PHYSICIAN'S NAME (Type) ELICOTT CITY, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-16-57	
22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE SEP 16 57	
24b. REGISTRAR'S SIGNATURE Research			

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 16 1957

RECEIVED

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1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Catonsville				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS 3235 Magnolia Avenue			
3. NAME OF DECEASED (Type or print) First Thomas Middle Coleine Last Curtin				4. DATE OF DEATH Month September Day 22 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 4, 1910	
9. AGE (In years by birthday) 47		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator				10b. KIND OF BUSINESS OR INDUSTRY Md. Glass Corp.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Homer Curtin				14. MOTHER'S MAIDEN NAME Hattie Coleine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W.W. II				16. SOCIAL SECURITY NO. 213-01-1120		17. INFORMANT Mrs. Pauline Curtin Address 3235 Magnolia Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia 357x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Friedereich's Ataxia DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 20 , 19 57 , to Sept. 22 , 19 57 , that I last saw the deceased alive on Sept. 22 , 19 57 , and that death occurred at 7:20p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 9-23-57 ACTUAL SIGNATURE Stella Wachslar M.D. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-26-57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR SEP 24 '57		24b. REGISTRAR'S SIGNATURE Overbaugh	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF BIRTH	
JAMES EARL RAY		5-6-38	
PLACE OF BIRTH		DATE OF DEATH	
MOBILE, ALABAMA		6-6-68	
OCCUPATION		CAUSE OF DEATH	
CONSTITUTIONAL		HEART DISEASE	
MANNER OF DEATH		PLACE OF DEATH	
NATURAL		HOSPITAL	
SEX		AGE	
MALE		30	
RACE		COLOR	
WHITE		WHITE	
RELIGION		EDUCATION	
METHODIST		HIGH SCHOOL	
MARRIAGE		SIGNED	
MARRIED		JAMES EARL RAY	
DATE OF MARRIAGE		DATE OF SIGNATURE	
1964		1968	
SIGNED		SIGNED	
JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE	
1968		1968	

BUREAU V. S.

SEP 25 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09187

9196

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 22 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton 2040.2	
f. STREET ADDRESS 115 Port Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THEODORE Middle DE Last SHIELDS		4. DATE OF DEATH Month September Day 18 Year 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 23, 1896
9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - gardener		10b. KIND OF BUSINESS OR INDUSTRY Nursery	
11. BIRTHPLACE (State or foreign country) Easton, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William De Shields		14. MOTHER'S MAIDEN NAME Pricilla Viney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTRO-INTESTINAL HEMORRHAGE DUE TO ADENOCARCINOMA OF STOMACH WITH LIVER METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 o. m. VA Month, Day, Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that attended VA attended the deceased from August 27, 1957 to September 18, 1957 and that death occurred at 4:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED HAROLD R. JOHNSON, M.D. VAH, FORT HOWARD, MARYLAND 9/18/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-20-57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Mortuary, 802 Madison Ave. Balto., Md.		24a. REC'D BY REGISTRAR Sept. 25. 57	
24b. REGISTRAR'S SIGNATURE Nelson L. Falker			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09188

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVE		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MARTIN BLVD. & RIVERTON RD.			d. STREET ADDRESS 401 N PORT STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle DURHAM Last			4. DATE OF DEATH Month SEPT. Day 21 Year 1957		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-23-31	9. AGE (In years last birthday) 26 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10b. KIND OF BUSINESS OR INDUSTRY NATIONAL CAY CO		11. BIRTHPLACE (State or foreign country) BALTIMORE MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME ABERHAM DURHAM			14. MOTHER'S MAIDEN NAME RACHEL CAMBELL		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. KOREAN WAR 400-349380		17. INFORMANT WANDA DURHAM 1624 E BALTIMORE ST	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) fracture of Skull- 822x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Crushed by Car overturning					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car overturned throwing victim out			
20c. TIME OF INJURY Month, Day, Year 4 Hour 9-21 1957		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Jack Collins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9-21-57	
EXAMINER'S NAME (Type) Jack Collins		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT 24 1957		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEM 5301 FREDERICK RD MD	
23. FUNERAL DIRECTOR'S SIGNATURE Supple BND		ADDRESS 1800 E LOMBARD ST		24a. REC'D BY REGISTRAR SEP 23 1957	
				24b. REGISTRAR'S SIGNATURE Edith Hurley	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

BUREAU V. 1

SEP 23 1957

RECEIVED

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09189
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. NAME OF DECEASED (Type or Print) FRANKLIN D EMANUEL		2. DATE OF DEATH 9-21-57	
3. PLACE OF DEATH A. Baltimore City Baltimore County		4. USUAL RESIDENCE A. STATE Md. B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Martin Blvd. and Riverton Rd.		C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)	
C. Length of stay in Baltimore 3 years Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 127 N. Broadway	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, (Specify) WIDOWED, DIVORCED Single	8. DATE OF BIRTH 2-28-37
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) shopman		10B. KIND OF BUSINESS OR INDUSTRY Chemical Co.	
11. BIRTHPLACE (State or foreign country) Robeson County, N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Emanuel		14. MOTHER'S MAIDEN NAME della porter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT steve Brewer 1323 Gage Ct.		ADDRESS	
18. 822X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSING INJURY OF CHEST		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST		(B) DUE TO (C)	
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II.		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET	21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? MARTIN BLVD & RIVERTON RD
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 9-21-57-4A.m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? AUTO OVERTURNED			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .			
23A. SIGNATURE B. K. Cohen		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> M.D. 9-21-57	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 9-24-57	24C. NAME OF CEMETERY OR CREMATORY zion Hill Baptist Centery	24D. LOCATION (City, town, or county) (State) Lumberton, N.C.
DATE RECEIVED BY REGISTRAR 9-21-57	REGISTRAR'S SIGNATURE Edith Hurler		25. FUNERAL DIRECTOR Frank Cvach & son 900 N. Chester st.

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WRITE WITH PET BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information should be carried. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9199

CERTIFICATE OF DEATH

09/90

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7122 MARSTON RD.</u>				d. STREET ADDRESS <u>7122 MARSTON RD.</u>			
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>J.</u> Last <u>FICKES</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 28, 1892</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Work for Sunpaper Co</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Wollet</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>172-01-3258</u>		17. INFORMANT Address <u>Mr Bennett Fickes 7122 Marston Rd BALTO</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Hypertensive cardio-</u> DUE TO (c) <u>vascular disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>obesity</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from _____, 1955, to _____, 1957, that I last saw the deceased alive on _____, 1957, and that death occurred at _____ P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Marvin H. Davis</u> M.D. <u>6512 Liberty Rd</u>				ADDRESS (Street, city or town, state) <u>Baltimore, Md</u>			
PHYSICIAN'S NAME (Type) <u>Marvin H. Davis</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 16, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Springville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Boiling Spring PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Fline & Sons Reisters Town, Md</u>				24a. REC'D BY REGISTRAR <u>DATE 9-13-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary B. Elmer</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 17 1957

RECEIVED

0-122 1/2nd F 5line

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09191

Reg. Dist. No.

44

9200

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS PT Baltimore</u>		c. LENGTH OF STAY IN 1b <u>WORK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (DUNDALK) 53</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethlehem Steel Co. Hospital</u>				d. STREET ADDRESS <u>8206 BLETZER Rd. 1</u> <u>224 N. Collington Ave.</u>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles SHERWOOD Fish, SR</u>				4. DATE OF DEATH Month Day Year <u>9 19 57</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH <u>MAY 2, 1918</u>		9. AGE (In years last birthday) <u>39</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.	
IF UNDER 1 YEAR	IF UNDER 24 HRS.							
Months Days	Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheeter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>				
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>JOSEPH FISH</u>				
14. MOTHER'S MAIDEN NAME <u>IDA JOHNSON</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>YES WW II</u>				
16. SOCIAL SECURITY NO. <u>239-24-4429</u>				17. INFORMANT Address <u>LEONA GREGORY FISH - SAME</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CRUSHING injury of head & compound fracture of skull</u> <u>902.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>fracture of skull</u> DUE TO (c) </td> <td> INTERVAL BETWEEN ONSET AND DEATH <u>INSTANTANEOUS</u> </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CRUSHING injury of head & compound fracture of skull</u> <u>902.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>fracture of skull</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>INSTANTANEOUS</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CRUSHING injury of head & compound fracture of skull</u> <u>902.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>fracture of skull</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>INSTANTANEOUS</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from roof</u>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>8:55</u> <u>XXXX</u> <u>9-19-57</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bethlehem Steel Co. Baltimore 19 Md.</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE <u>JACK C. COLLINS</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SKINED <u>9-19-57</u>				
EXAMINER'S NAME (Type) <u>M. B. Davis, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HILLINGTON, N.C.</u>				
22d. LOCATION (City, town, or county) (State) <u>HILLINGTON, N.C.</u>		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <u>SEP 23 1957</u> <u>Seaton L. Sharkey</u>						
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>White Birch Road, Dundalk 22, Md.</u>								

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09192

CERTIFICATE OF DEATH

Reg. Dist. No. 35

9201

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUTHERVILLE		c. LENGTH OF STAY IN 1b x2 LUTHERVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARITA Middle HATTIE B. Last FISHER		4. DATE OF DEATH Month SEPT. Day 3. Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 30. 1879
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EMANUEL FISHER		14. MOTHER'S MAIDEN NAME LAURA ROYSTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT FAMILY RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 421.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Failure (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 3 yrs. 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1 , 1957, to Sept. 3 , 1957, that I last saw the deceased alive on Sept. 2 , 1957, and that death occurred at 8:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE G. T. GILMORE M.D.		ADDRESS (Street, city or town, state) Lutherville, Md.	
PHYSICIAN'S NAME (Type) G. T. GILMORE		DATE SIGNED 9/5/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 6, 1957	
22c. NAME OF CEMETERY OR CREMATORY POPLAR GROVE CEM.		22d. LOCATION (City, town, or county) (State) COCKEYSVILLE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Md.		24a. REC'D BY REGISTRAR DATE Sept. 5, 1957	
24b. REGISTRAR'S SIGNATURE Mabel C. Gray			

MEDICAL CERTIFICATION

RECEIVED

SEP 6 1957

BUREAU V. S.

John Brown, Texas, Texas, Tex.
Sept 6, 1957

NAME — HOME FAMILY RECORDS

EMILY FISH

WIFE

FEMALE WHITE X

~~MARTHA~~ HATTIE B.

FISHER

SPRING AVE.

CUTHERVILLE

BALTIMORE

MARYLAND

BALTIMORE

11 THERIALE

SPRING AVE.

SEPT. 3.

21

9242

CERTIFICATE OF DEATH

09193.

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		BALTO.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence after admission) a. STATE		Md.		b. COUNTY		BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Overlea		c. LENGTH OF STAY IN lb		6 mo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		x2103 W. Fuller			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		103 W. Fuller Ave		d. STREET ADDRESS		103 W. Fuller Ave		e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day Year	
Edward Bernard Fowler								Sept 9				1957	
5. SEX		Male		6. COLOR OR RACE		White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		Sept 24 1942	
9. AGE (In years last birthday) yrs.		14		IF UNDER 1 YEAR		Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		At School		10b. KIND OF BUSINESS OR INDUSTRY		None		11. BIRTHPLACE (State or foreign country)		Balto. Co.		12. CITIZEN OF WHAT COUNTRY?	
Sterling Fowler				Barbara G. Langner								U.S.A	
13. FATHER'S NAME		Sterling Fowler		14. MOTHER'S MAIDEN NAME		Barbara G. Langner							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war & dates of service)		No		16. SOCIAL SECURITY NO.		None		17. INFORMANT		Address		Sterling Fowler 103 W. Fuller Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		200.0		DU TO		Pulmonary Edema		INTERVAL BETWEEN ONSET AND DEATH		4 hours			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		Generalized Sarcoma		18 months							
(c)		Reticulum ill Sarcoma		2 years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 1956, to September 9, 1957, that I last saw the deceased alive on September 9, 1957, and that death occurred at 7:00 P.M., from the causes and on the date stated above.		Paul G. Mueller		ADDRESS (Street, city or town, state)		DA'E SIGNED							
ACTUAL SIGNATURE		PAUL G. MUELLER		6331 BELAIR RD. BALTIMORE MD									
PHYSICIAN'S NAME (Type)		PAUL G. MUELLER		6331 BELAIR RD. BALTIMORE MD									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)							
Burial		Sept 12-57		Parkwood Cem.		12101 AVE Balto. Co. Md.							
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
Daniel R. 7110 Belair Rd.		DATE		SEP 13 1957		Mrs. J. R. Roper							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

BUREAU V. S.

SEP 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

091944

9203

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 51 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4	
3. NAME OF DECEASED (Type or print) First HAYES Middle H. Last FRAZIER		4. DATE OF DEATH Month September Day 21 Year 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/30/15
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chrome Acid Operator		10b. KIND OF BUSINESS OR INDUSTRY Chemical Co.	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hayes Frazier		14. MOTHER'S MAIDEN NAME Mary Parker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII		16. SOCIAL SECURITY NO. 242-10-4345	
17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG LEFT, WITH LIVER METASTASIS 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1 , 19 57 to September 21 19 57 . That I saw the deceased XXXXXX and that death occurred at 9:45 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Harold R. Johnson M.D. Veterans Administration Hospital 9/21/57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON, M. D. Fort Howard, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-25-57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		24a. REC'D BY REGISTRAR DATE 9/23/57	
24b. REGISTRAR'S SIGNATURE Lawson L. Farley			

VS A15 (4)
15M 9/55

Charles R. Law, Mortuary 802-04 Madison Ave, Balto., Md.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. 3.

SEP 24 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

39

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jacksonville</i>		c. LENGTH OF STAY IN 1b <i>37 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Jarrettsville Pike</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Theodore Edward Gengnagel</i>		4. DATE OF DEATH <i>Sept. 1, 1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>23 August 1880</i>
9. AGE (In years last birthday) <i>77 yrs.</i>		10. IF UNDER 1 YEAR: Months <i>7</i> Days <i>7</i> Hours <i>7</i> Min. <i>7</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Butcher</i>	
11. BIRTHPLACE (State or foreign country) <i>Highland town, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George W. Gengnagel</i>		14. MOTHER'S MAIDEN NAME <i>Sophie Maasch</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>Daughter</i>		Address <i>Mrs Ohler - Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of prostate</i> DUE TO (b) <i>Cancer of prostate</i> DUE TO (c) <i>10 yrs</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i> <i>10 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug. 1957</i> to <i>Sept. 1957</i> , that I last saw the deceased alive on <i>31 Aug. 1957</i> , and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walter T. Kees</i> M.D.		DATE SIGNED <i>Sept 9-1-57</i>	
PHYSICIAN'S NAME (Type) <i>Walter T. KEES</i>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>Sept 4 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Chestnut Grove</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Co. Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Burgee Funeral Home</i> ADDRESS <i>3631 Falk Road</i>		24a. REC'D BY REGISTRAR DATE <i>9/5/57</i>	
24b. REGISTRAR'S SIGNATURE <i>Ely G. Goss</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 104

NAME OF DECEASED		SEX		AGE	
MRS. W. J. B. B. B.		F		45	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JAN 10 1957		BALTIMORE, MD.		HEART DISEASE	
TIME OF DEATH		OCCUPATION		EDUCATION	
10:00 AM		HOUSEWIFE		HIGH SCHOOL	
MANNER OF DEATH		RACE		RELIGION	
NATURAL		WHITE		METHODIST	
PLACE OF BIRTH		DATE OF BIRTH		PLACE OF DEATH	
BALTIMORE, MD.		JAN 10 1957		BALTIMORE, MD.	
NAME OF PHYSICIAN		NAME OF FUNERAL HOME		NAME OF BURIAL PLACE	
DR. J. B. B. B.		B. B. B. B. B.		B. B. B. B. B.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE	
[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 10 1957		JAN 10 1957		JAN 10 1957	

BUREAU V. B.

JAN 5 1957

RECEIVED

MICHIGAN STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09196
Item 18 Film 221 10-7-57										9205
CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 19 Evans Ave					d. STREET ADDRESS 19 Evans Ave.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle Sunday Last Gerstmyer					4. DATE OF DEATH Month Sept. Day 11 , 1957 Year 19					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1916		9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Parts manufact		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Robert B. Gerstmyer					14. MOTHER'S MAIDEN NAME Elsie Y. Tarbert					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WWII 215-07-8858		17. INFORMANT Address Marlene Gerstmyer, 19 Evans Ave. Timonium						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X Carcinomatosis DUE TO Carcinoma of Rectum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from February, 1957 , to Sept 11th, 1957 , that I last saw the deceased alive on Sept 11th, 1957 , and that death occurred at 3:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1927 York Rd, Timonium, Md. DATE SIGNED 9/12/57 ACTUAL SIGNATURE M. K. Quinn M.D. 1927 York Rd, Timonium, Md. PHYSICIAN'S NAME (Type) M. K. QUINN										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 14/57		22c. NAME OF CEMETERY OR CREMATORY Prospect Hill		22d. LOCATION (City, town, or county) (State) Towson, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, inc. 1050 York Rd. Tow. 4					24a. REC'D BY REGISTRAR SEPT 17 1957		24b. REGISTRAR'S SIGNATURE H. H. H. H.			

MEDICAL CERTIFICATION

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Sec 10-7-57

1

DP

CERTIFICATE OF DEATH

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BUREAU V. S.

SEP 18 1957

RECEIVED

9206

CERTIFICATE OF DEATH

09197

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home 5743 Edmondson Avenue		d. STREET ADDRESS 4770 Elison Avenue	
3. NAME OF DECEASED (Type or print) Lydia A. Gessner		4. DATE OF DEATH Month September Day 10 Year 1957	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1871
9. AGE (In years last birthday) yrs. 86		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph J. Gessner, Sr.,		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Joseph J. Gessner, 4770 Elison Avenue		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma, generalized 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease			
INTERVAL BETWEEN ONSET AND DEATH 1 year			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 16, 1957 , to Sept. 10, 1957 , that I last saw this deceased alive on Sept. 9, 1957 and that death occurred at 11:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Sept. 12, 1957			
ACTUAL SIGNATURE John F. Schaeffer M.D.		PHYSICIAN'S NAME (Type) JOHN F. SCHAEFFER, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-14-57	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24. REGISTRAR'S SIGNATURE SEP 16 57	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

File No.

1

BUREAU V. 8

SEP 16 1957

RECEIVED

9157

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MD b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 DUNDALK 22			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DUNKIRK APTS. SHIPPING PLACE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM JAMES GODFREY				4. DATE OF DEATH Month Day Year 9/25/57 19			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC 10, 1910	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRAFTSMAN		10b. KIND OF BUSINESS OR INDUSTRY STEEL MFGR.	
11. BIRTHPLACE (State or foreign country) PENNA		12. CITIZEN OF WHAT COUNTRY? U.S. A.		13. FATHER'S NAME JAMES D. GODFREY		14. MOTHER'S MAIDEN NAME LURENA MCGINNIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 207 01-962		17. INFORMANT MARGARET L. GODFREY - Address SAME			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) disease				INTERVAL BETWEEN ONSET AND DEATH 1 YEAR.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1, 1956 , to Sep 25, 1957 , that I last saw the deceased alive on Sep 23, 1957 , and that death occurred at 9:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE David H. Andrew M.D.				ADDRESS (Street, city or town, state) 33 Dundalk Ave		DATE SIGNED 9/27/57	
PHYSICIAN'S NAME (Type) David H. Andrew MD				DUNDALK MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/30/57		22c. NAME OF CEMETERY OR CREMATORY WASHBURN ST. CEM.		22d. LOCATION (City, town, or county) (State) SCRANTON, PENNA.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Louis Buckley, Dundalk, Md.				24a. REC'D BY REGISTRAR Mr. Tully		24b. REGISTRAR'S SIGNATURE	
				DATE SEP 30 1957			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 30

SEP 30 1957

BUREAU V. 8

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09199 44

9297

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster 06 x 1.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS Route 5	
3. NAME OF DECEASED (Type or print) First ROY Middle C Last GRAHAM		4. DATE OF DEATH Month September Day 21 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/10/91
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George T. Graham		14. MOTHER'S MAIDEN NAME Susan Hamilton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. 220-34-5402	
17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER OF THE LUNG WITH METASTASES DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 16 , 19 57 , to September 21 19 57 . I am a physician and that death occurred at 9:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED HAROLD R. JOHNSON M.D. Veterans Administration Hospital 9/22/57			
ACTUAL SIGNATURE HAROLD R. JOHNSON M.D. Veterans Administration Hospital 9/22/57			
PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON, M. D. Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-24-1957	
22c. NAME OF CEMETERY OR CREMATORY St. James Cemetery		22d. LOCATION (City, town, or county) (State) Dennings, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR SEP 24 1957		24b. REGISTRAR'S SIGNATURE Harold R. Johnson	

VS A15 (4)
15M 9/55

C. Miller Waltz, Jr. Sykesville, Maryland

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. 2

SEP 24 1957

RECEIVED

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
OCCUPATION		SEX	
EDUCATION		MARRIAGE	
RELIGION		RACE	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09200

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balts.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>17 Pelczar Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>David</u> First <u>GRIGGIN-GREER</u> Middle <u>GRIGGIN-GREER</u> Last				4. DATE OF DEATH Month <u>Sept</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 11-1913</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>12</u> Min.		IF UNDER 24 HRS. Hours <u>12</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>			
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>John M. Greer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Beckman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>412-18-7440</u>			
17. INFORMANT <u>Ruby Greer</u> Address <u>Same</u>							
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack C. Collins</u>				DATE SIGNED <u>9-4-57</u>			
EXAMINER'S NAME (Type) <u>Jack C. Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>9-5-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lowrence Tenn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Christine Bruzdziński</u> ADDRESS <u>1407 Eastern Ave</u>				24a. REC'D BY REGISTRAR <u>SEP 6</u>		24b. REGISTRAR'S SIGNATURE <u>Edith A. Harris</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NAME: David Green
AGE: 45
SEX: Male
DATE OF BIRTH: Jan 11 1913
PLACE OF BIRTH: New York
OCCUPATION: Constellation Team
CAUSE OF DEATH: Heart Attack
MANNER OF DEATH: Natural

BUREAU V. 2

APR 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9209

CERTIFICATE OF DEATH

092014

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere				c. LENGTH OF STAY IN 1b About 30 yrs. X0 Edgemere			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box No. 530 Rt. 10. #19 Zone				d. STREET ADDRESS Box No. 530 Rt. 10. #19 Zone			
3. NAME OF DECEASED (Type or print) First ROY Middle E. Last HAINES				4. DATE OF DEATH Month Sept. Day 19 Year 19 57.			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13, 1910		9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Television Repairman				10b. KIND OF BUSINESS OR INDUSTRY 20th Century		11. BIRTHPLACE (State or foreign country) Selinsgrove, Pa.	
13. FATHER'S NAME John W. Haines				14. MOTHER'S MAIDEN NAME Emma L. Stimeling			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Pauline B. Haines		Address Same.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c) ---						INTERVAL BETWEEN ONSET AND DEATH 1 hr. 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 19 54 to Sept 19, 19 57 , that I last saw the deceased alive on Sept. 14, 19 57 , and that death occurred at 8:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. T. McQuis				ADDRESS (Street, city or town, state) 520 D St. Balt Md			
PHYSICIAN'S NAME (Type) J. T. McQuis				DATE SIGNED 9/21/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-23-57		22c. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE		22d. LOCATION (City, town, or county) (State) ELK RIDGE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John L. Gile				ADDRESS 921 S. CONKLING ST. BALTO, MD.		24a. REC'D BY REGISTRAR 23 1957	
				24b. REGISTRAR'S SIGNATURE Lawson L. Gile			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 23 1957

RECEIVED

41

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9210 CERTIFICATE OF DEATH

09202

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2Yrs.3 Mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle K. Last Hall		4. DATE OF DEATH Month September Day 21 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1869
9. AGE (In years lost birthday) 88 yrs.		IF UNDER 1 YEAR Months 8 Days 8	IF UNDER 24 HRS. Hours 8 Min. 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At. Home		10b. KIND OF BUSINESS OR INDUSTRY Davie Co. North Carolina	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David Shoaf		14. MOTHER'S MAIDEN NAME Camoline Hendricks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Charles Anderson, 106 Cherrydell Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Cardio Vasc disease DUE TO (c) ox			INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1955 to Sept 21 1957 , that I last saw the deceased alive on Sept 20 1957 , and that death occurred at 7:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Cliff Ratliff, Jr. M.D.		ADDRESS (Street, city or town, state) 4605 Edmondson Ave DATE SIGNED 9/24/57	
PHYSICIAN'S NAME (Type) CLIFF RATLIFF, JR.		4605 EDMONDSON AVE. 9/24/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-24-57	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Elsworth Armacost ADDRESS 4600 Liberty Hgts. Ave.		24a. REC'D BY REGISTRAR SEP 26 57 DATE SEP 26 57 24b. REGISTRAR'S SIGNATURE W. H. Smith	

MASSACHUSETTS DEPARTMENT OF HEALTH-CERTIFICATE NO. 10

SEP 26 1957

RECEIVED

CERTIFICATE OF DEATH

09203

Reg. Dist. No.

9211

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurman				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armocost Nursing Home-Regester Ave.				d. STREET ADDRESS 4419 Marble Hall Rd.			
3. NAME OF DECEASED (Type or print) First NANNIE Middle M. Last HARN				4. DATE OF DEATH Month Sept. Day 12, Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1869		9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Henry Bopst				14. MOTHER'S MAIDEN NAME Louisa			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mr. John E. Harn - 4646 Marble Hall Rd. #12			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 12 DAYS YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)		
20f. (City or town)			20g. (County)			20h. (State)	
21. I certify that I attended the deceased from AUG. 31, 1957 , to SEPT. 12, 1957 , that I last saw the deceased alive on SEPT. 12, 1957 , and that death occurred at 9:15 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1532 HAVENWOOD ROAD BALTIMORE-18, MD DATE SIGNED							
ACTUAL SIGNATURE Arthur K. Biregin M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) ARTHUR K BIREGIN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/16/57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickerson & Sons - Baltimore				24a. REC'D BY REGISTRAR SEP 16 1957			
24b. REGISTRAR'S SIGNATURE Michael Gray							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 17 1957

RECEIVED

CERTIFICATE OF DEATH

9212

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockey'sville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockey'sville</i>			
c. LENGTH OF STAY IN 1b <i>2 wks</i>				d. STREET ADDRESS <i>Shawan Rd</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Shawan Rd</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Dora</i> Middle <i>Abigail</i> Last <i>Harrell</i>				4. DATE OF DEATH Month <i>Sept</i> Day <i>9</i> Year <i>1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>13 Oct 1875</i>	
9. AGE (In years last birthday) <i>81</i> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Carroll Co. Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Jonathan Nester</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Correll</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service) <i>-</i>				16. SOCIAL SECURITY NO. <i>none</i>			
17. INFORMANT <i>Stella Nester</i>				Address <i>same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompenstation</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arterio sclerotic cardiovascular disease</i> DUE TO (c) <i>17 yrs</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <i>August</i> , 19 <i>57</i> , to <i>9 Sept 57</i> , that I last saw the deceased alive on <i>6 Sept 57</i> , and that death occurred at <i>1 A</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Walter T. Kees</i>				DATE SIGNED <i>Cockey'sville Md 9 Sept 57</i>			
PHYSICIAN'S NAME (Type) <i>Walter T Kees</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-12-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>New Dublin Presbyterian</i>		22d. LOCATION (City, town, or county) <i>Dublin Virginia</i> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <i>L. Scott Brooks</i>				ADDRESS <i>627 York Rd, Towson, Md.</i>		24a. REC'D BY REGISTRAR <i>SEP 11 57</i>	
				24b. REGISTRAR'S SIGNATURE <i>Abigail</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		Male		White		April 14, 1928		Jackson, Tennessee	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
Married		April 14, 1954		St. Louis, Missouri		April 4, 1968		St. Louis, Missouri		Suicide	
OCCUPATION		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
Attorney		April 4, 1968		St. Louis, Missouri		April 4, 1968		St. Louis, Missouri		Suicide	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
April 4, 1968		St. Louis, Missouri		April 4, 1968		St. Louis, Missouri		April 4, 1968		St. Louis, Missouri	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
April 4, 1968		St. Louis, Missouri		April 4, 1968		St. Louis, Missouri		April 4, 1968		St. Louis, Missouri	

BUREAU V. S.

SEP 11 1967

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO MAINTAIN THE ACCURACY OF THE RECORDS AND TO FURNISH COPIES OF THE SAME TO THE REQUESTER. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THE CERTIFICATE OF DEATH.

9213

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 84 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. STREET ADDRESS 112 AVONDALE CIRCLE			
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS A HARRIS				4. DATE OF DEATH Month Day Year SEPTEMBER 19 19 57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 24, 1913	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME FRANK E. HARRIS			14. MOTHER'S MAIDEN NAME CHARLOTTE KRAM				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-11 183-03-8919		17. INFORMANT Address CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL METASTASIS 163X DUE TO CARCINOMA OF THE LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 1 YEAR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from JUNE 27 , 19 57 , to SEPT. 19 , 19 57 . that I saw the deceased alive on and that death occurred at 1:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 9-19-57							
ACTUAL SIGNATURE <i>Roland Ponce de Leon</i>		M.D. VAH, FORT HOWARD, MARYLAND					
PHYSICIAN'S NAME (Type) ROLAND PONCE de LEON		M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-23-57	22c. NAME OF CEMETERY OR CREMATORY ANNAPOLIS NATIONAL CEMETERY ANNAPOLIS, MARYLAND		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE JOHN TAYLOR & SONS		ADDRESS 147 Duke of Gloucester St., Annapolis, Maryland.		24a. REC'D BY REGISTRAR DATE 9/23/57		24b. REGISTRAR'S SIGNATURE <i>Dawson L. Furbess</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

BUREAU V. 5

SEP 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09206

48

9167

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe				c. LENGTH OF STAY IN 1b 6 Yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Halethorpe				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4417 Linden Ave.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 4417 Linden Ave.,			
3. NAME OF DECEASED (Type or print) First Mattie Elizabeth Middle Harvey Last				4. DATE OF DEATH Month Sept. Day 1, Year 19 57.			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 20, 1877	
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY --			
11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John D. Childs				14. MOTHER'S MAIDEN NAME Sophonria Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mrs. Kenneth J. Baumann				Address 4417 Linden Ave. (27)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral and right popliteal thromb; about 3 weeks DUE TO (c) Arteriosclerotic Cardiovascular Disease years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) atrophic arthritis & stenocardia							
INTERVAL BETWEEN ONSET AND DEATH terminal							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 50 , to Sept 1, 19 57 , that I last saw the deceased alive on Sept 1, 19 57 , and that death occurred at 2:40 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4335 Park Heights Ave. DATE SIGNED 9/3/57							
ACTUAL SIGNATURE Louis R. Maser M.D. M.D. 4335 Park Heights Ave.							
PHYSICIAN'S NAME (Type) Louis R. Maser M.D. 4335 Park Heights Ave.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-4-1957		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard Strong ADDRESS 3107 W. North Ave.							
24a. REC'D BY REGISTRAR SEP 4 1957				24b. REGISTRAR'S SIGNATURE Dr. M. Kuffner			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS	
22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS	
28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS	
34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS	
40. SIGNATURE OF WITNESS		41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS	
43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS	
46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS		51. SIGNATURE OF WITNESS	
52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS	
55. SIGNATURE OF WITNESS		56. SIGNATURE OF WITNESS		57. SIGNATURE OF WITNESS	
58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS	
64. SIGNATURE OF WITNESS		65. SIGNATURE OF WITNESS		66. SIGNATURE OF WITNESS	
67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS		69. SIGNATURE OF WITNESS	
70. SIGNATURE OF WITNESS		71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS	
79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS		81. SIGNATURE OF WITNESS	
82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS	
88. SIGNATURE OF WITNESS		89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS		93. SIGNATURE OF WITNESS	
94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS		96. SIGNATURE OF WITNESS	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS	
100. SIGNATURE OF WITNESS		101. SIGNATURE OF WITNESS		102. SIGNATURE OF WITNESS	

BUREAU V. S.

SEP 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9214

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4	
c. LENGTH OF STAY IN 1b <u>13 days</u>		d. STREET ADDRESS <u>1008 N. Monroe Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RUSSELL</u> Middle <u>I.</u> Last <u>HARVEY</u>		4. DATE OF DEATH Month <u>September</u> Day <u>22</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/15/22</u>
9. AGE (In years last birthday) <u>35</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Clerk</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Harvey</u>		14. MOTHER'S MAIDEN NAME <u>Aline Dorsey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>218-12-2189</u>	
17. INFORMANT <u>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>446X</u> DUE TO <u>ARTERIOULAR NEPHROSCLEROSIS AND CHRONIC</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GLOMERULONEPHRITIS</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u> <u>1 YEAR</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>September 9, 19 57</u> to <u>September 22 19 57</u> and that death occurred at <u>3:10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>CHIEN WEI LAN</u>		M.D. <u>Veterans Administration Hospital</u> <u>9/23/57</u>	
PHYSICIAN'S NAME (Type) <u>Chien Wei Lan</u>		Fort Howard, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-26-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bush Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cooksville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>		24. REGISTRAR'S SIGNATURE <u>Danson L. Farber</u>	

BUREAU V. S.

SEP 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9215

CERTIFICATE OF DEATH

0920838

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. LENGTH OF STAY IN 1b <u>35 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Baltimore X2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>602 Murdock Road</u>			d. STREET ADDRESS <u>602 Murdock Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary Elizabeth</u> Middle <u>Heim</u> Last <u></u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>15</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10, 1875</u>	9. AGE (In years lost birthday) yrs. <u>82</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Prince George's Cty, Md.</u>	
13. FATHER'S NAME <u>Joseph Ireland</u>			14. MOTHER'S MAIDEN NAME <u>Martha ?</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Warner D. Heine, Jr. 916 Litchfield Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u></u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>		20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>Sept.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>13th Sept</u> , 19 <u>57</u> , and that death occurred at <u>9:40 P.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>M. X. Quinn</u>		ADDRESS (Street, city or town, state) <u>1927 York Rd T. MONROE</u>			
PHYSICIAN'S NAME (Type) <u></u>		DATE SIGNED <u>9/16/57</u>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Buried</u>		22b. DATE THEREOF <u>9/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Govans Presbyterian Cem. Baltimore, Maryland</u>	
22d. LOCATION (City, town, or county) <u></u>		22e. (State) <u></u>		22f. (County) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u>		ADDRESS <u>-3000 E. Baltimore Street</u>		24a. REC'D BY REGISTRAR <u></u>	
24b. REGISTRAR'S SIGNATURE <u>Mabel</u>		DATE <u>SEP 18 1957</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. OCCUPATION		11. EDUCATION		12. MARITAL STATUS	
13. PREVIOUS ILLNESS		14. PRESENT ILLNESS		15. DATE OF ONSET	
16. DATE OF DEATH		17. TIME OF DEATH		18. PLACE OF DEATH	
19. CAUSE OF DEATH		20. MANNER OF DEATH		21. PLACE OF BIRTH	
22. OCCUPATION		23. EDUCATION		24. MARITAL STATUS	
25. PREVIOUS ILLNESS		26. PRESENT ILLNESS		27. DATE OF ONSET	
28. DATE OF DEATH		29. TIME OF DEATH		30. PLACE OF DEATH	
31. CAUSE OF DEATH		32. MANNER OF DEATH		33. PLACE OF BIRTH	
34. OCCUPATION		35. EDUCATION		36. MARITAL STATUS	
37. PREVIOUS ILLNESS		38. PRESENT ILLNESS		39. DATE OF ONSET	
40. DATE OF DEATH		41. TIME OF DEATH		42. PLACE OF DEATH	
43. CAUSE OF DEATH		44. MANNER OF DEATH		45. PLACE OF BIRTH	
46. OCCUPATION		47. EDUCATION		48. MARITAL STATUS	
49. PREVIOUS ILLNESS		50. PRESENT ILLNESS		51. DATE OF ONSET	
52. DATE OF DEATH		53. TIME OF DEATH		54. PLACE OF DEATH	
55. CAUSE OF DEATH		56. MANNER OF DEATH		57. PLACE OF BIRTH	
58. OCCUPATION		59. EDUCATION		60. MARITAL STATUS	
61. PREVIOUS ILLNESS		62. PRESENT ILLNESS		63. DATE OF ONSET	
64. DATE OF DEATH		65. TIME OF DEATH		66. PLACE OF DEATH	
67. CAUSE OF DEATH		68. MANNER OF DEATH		69. PLACE OF BIRTH	
70. OCCUPATION		71. EDUCATION		72. MARITAL STATUS	
73. PREVIOUS ILLNESS		74. PRESENT ILLNESS		75. DATE OF ONSET	
76. DATE OF DEATH		77. TIME OF DEATH		78. PLACE OF DEATH	
79. CAUSE OF DEATH		80. MANNER OF DEATH		81. PLACE OF BIRTH	
82. OCCUPATION		83. EDUCATION		84. MARITAL STATUS	
85. PREVIOUS ILLNESS		86. PRESENT ILLNESS		87. DATE OF ONSET	
88. DATE OF DEATH		89. TIME OF DEATH		90. PLACE OF DEATH	
91. CAUSE OF DEATH		92. MANNER OF DEATH		93. PLACE OF BIRTH	
94. OCCUPATION		95. EDUCATION		96. MARITAL STATUS	
97. PREVIOUS ILLNESS		98. PRESENT ILLNESS		99. DATE OF ONSET	
100. DATE OF DEATH		101. TIME OF DEATH		102. PLACE OF DEATH	

RECEIVED
SEP 18 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9216

CERTIFICATE OF DEATH

09209
Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN 1b 39 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 1831 N. Linden Ave.			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ARMINIUS First NONE Middle HENDERSON Last		4. DATE OF DEATH September Month 21 Day 19 Year 57					
5. SEX MALE	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1988	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Store		11. BIRTHPLACE (State or foreign country) Richmond, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred				14. MOTHER'S MAIDEN NAME Rose Rich			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 220-05-0971		17. INFORMANT Clin Rec. Vet Adm Hosp. Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE MYELOMA 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 Months					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Aug 13 19 57 , to Sept 21 19 57 and that death occurred at 12:20AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Veterans Administration Hospital DATE SIGNED DR. George Vash ACTUAL SIGNATURE DR. George Vash M.D. Fort Howard, Maryland PHYSICIAN'S NAME (Type) DR. George Vash							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-25-57	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) 5501 Frederick Rd Balto Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Wm. A. Jackson Funeral Home			ADDRESS 916 Penna. #1		24a. REC'D BY REGISTRAR SEP 24 1957	24b. REGISTRAR'S SIGNATURE Jawson Park	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 24 1957

RECEIVED

9217 CERTIFICATE OF DEATH

Reg. Dist. No.

0921038

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<u>Baltimore, Maryland</u>		<u>Baltimore, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stella Maris Hospice</u> <u>Lowson-Balto.</u> <u>1- Maryland</u>		d. STREET ADDRESS <u>1609 E. 29th Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Matilda</u> Last <u>Hickman</u>		4. DATE OF DEATH Month <u>September</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/2/1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	
<u>Housekeeper</u>		<u>Lowell, Massachusetts</u>	
13. FATHER'S NAME <u>Thomas Mooney</u>		14. MOTHER'S MAIDEN NAME <u>Helen Murphy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>225-32-2539</u>	
17. INFORMANT <u>HOSP. RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>18 months</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July, 1955</u> to <u>September, 1957</u> , that I last saw the deceased alive on <u>September 7, 1957</u> , and that death occurred at <u>Lowell, Mass.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. Donnell</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>7501 York Rd 9/7/57</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>9/11/57</u>	<u>Ferncliff</u>	<u>Ardsley, N.Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>MacNabb & Sons</u>		24a. REC'D BY REGISTRAR <u>SEP 11 1957</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATEMENT OF HEALTH - ONE 12
CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
AGE		SEX	
RACE		OCCUPATION	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
EDUCATION		RELIGION	
PREVIOUS ILLNESS		CAUSE OF DEATH	
DATE OF ONSET		PLACE OF DEATH	
DATE OF EXAMINATION		EXAMINER'S SIGNATURE	
FAMILY HISTORY		SOCIAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY TESTS	
TREATMENT		PATHOLOGICAL FINDINGS	
HISTORICAL DATA		FINAL DIAGNOSIS	
FAMILY HISTORY		SOCIAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY TESTS	
TREATMENT		PATHOLOGICAL FINDINGS	
HISTORICAL DATA		FINAL DIAGNOSIS	

BUREAU V. S.

SEP 11 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09211 33

9218

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Md. c. LENGTH OF STAY IN 1b Baltimore 23, Maryland d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 23, Maryland d. STREET ADDRESS 1013 West Fayette Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lelia Middle Higgins Last Higgins		4. DATE OF DEATH Month 9 Day 3 Year 19 57	
5. SEX F	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/19/43
9. AGE (In years last birthday) 14 yrs.		10. IF UNDER 1 YEAR Months 14 Days 14 Hours 14 Min.	11. IF UNDER 24 HRS. Months 14 Days 14 Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Student	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Al Higgins		14. MOTHER'S MAIDEN NAME Belle McDowell (deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Rosewood Records		Address 2701 Home	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status Epilepticus 753.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Microcephaly DUE TO (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
INTERVAL BETWEEN ONSET AND DEATH since birth			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. ---		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from 10/15/56 , 19____, to 9/3/57 , 19____, that I last saw the deceased alive on 9/3/57 , 19____, and that death occurred at 8:05 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) --- DATE SIGNED ---			
ACTUAL SIGNATURE Harry G. Butler M.D. ---			
PHYSICIAN'S NAME (Type) Harry G. Butler, M.D. Rosewood Training School, Owings Mills, Md.			
22a. BURIAL CREMATION REMOVAL (Specify) ---		22b. DATE THEREOF 9/4/57	
22c. NAME OF CEMETERY OR CREMATORY ---		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank D. Newell		24. REC'D BY REGISTRAR ---	
24b. REGISTRAR'S SIGNATURE Mary Elmer		DATE SEP 6 1957	

CERTIFICATE OF DEATH

Name of Deceased _____		Date of Death _____	
Sex _____		Age _____	
Usual Residence _____		Place of Death _____	
Cause of Death _____		Manner of Death _____	
Physician's Signature _____		Registrar's Signature _____	
Date of Certificate _____		Place of Issuance _____	

BUREAU V. S.

SEP 6 1967

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9219

CERTIFICATE OF DEATH

Reg. Dist. No. 09212 35-

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>York</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Freedom</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		d. STREET ADDRESS <u>Telna Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Middle Town Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>C.</u> Last <u>Hoffman</u>		4. DATE OF DEATH <u>Sept. 10, 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 28, 1872</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Glen Rock, Pa. RD. 2, S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cincinnati Hoffman</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Fillmore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>_____</u>	
17. INFORMANT <u>Mrs. Wilbur Deemy, New Freedom, Pa.</u>		Address <u>_____</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular disease</u> DUE TO <u>_____</u> (c) <u>_____</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>_____</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>_____</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>_____</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1956</u> to <u>Sept 9, 1957</u> , that I last saw the deceased alive on <u>Sept 9, 1957</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul D. Shaub</u> M.D.		ADDRESS (Street, city or town, state) <u>Shrewsbury Pa</u> DATE SIGNED <u>9-11-57</u>	
PHYSICIAN'S NAME (Type) <u>Paul D. Shaub, M.D.</u>		Shrewsbury, Pa.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 12, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Steltz Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Rock, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Hartenstein, New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>9/13/57</u> 24b. REGISTRAR'S SIGNATURE <u>Gloria L. Facion</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		1945		MEMPHIS, TENNESSEE		JANE E. RAY		4/4/68		MEMPHIS, TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		SOCIETY	
HEART DISEASE		NATURAL		DRIVER		HIGH SCHOOL		METHODIST		MEMBER	
DETAILS OF ILLNESS		DATE OF ONSET		DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH	
HEART ATTACK		4/3/68		4/4/68		10:00 AM		10:00		00	
PREVIOUS ILLNESS		DATE OF ONSET		DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH	
NONE		NONE		NONE		NONE		NONE		NONE	
SIGNS AND SYMPTOMS		DATE OF ONSET		DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH	
Chest pain, shortness of breath		4/3/68		4/4/68		10:00 AM		10:00		00	
TREATMENT		DATE OF ONSET		DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH	
None		None		None		None		None		None	
POST-MORTEM		DATE OF ONSET		DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH	
None		None		None		None		None		None	
BURIAL		DATE OF ONSET		DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH	
Buried		None		None		None		None		None	
Cremation		None		None		None		None		None	
Other		None		None		None		None		None	

BUREAU V. 3

SEP 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9220

CERTIFICATE OF DEATH

09213
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Con.Home		d. STREET ADDRESS 207 Rock Glen Road	
3. NAME OF DECEASED (Type or print) First Rezin Middle M. Hood Last		4. DATE OF DEATH Month Sept. Day 19 Year 1957	
5. SEX M	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1867
9. AGE (In years last birthday) yrs. 90		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis F. Hood		14. MOTHER'S MAIDEN NAME Martha Sanborn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Virginia G. Hood, 809 Woodington Rd		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL ARTERIO SCLEROSIS DUE TO (c) GENERAL ARTERIOSCLEROSIS..... 1-2 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 0	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APR. 25, 1957 to SEPT. 19, 1957 , that I last saw the deceased alive on SEPT. 10, 1957 , and that death occurred at 1:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE S. Lloyd Johnson M.D.			
PHYSICIAN'S NAME (Type) S. LLOYD JOHNSON, M.D. 6348 FREDERICK ROAD, CATONSVILLE, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 21/57	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Balto. 29, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Edmondson Directors 4101 Edmondson Ave		24a. REC'D BY REGISTRAR DATE SEP 23 57	
24b. REGISTRAR'S SIGNATURE Archer			

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. 5

SEP 23 1957

RECEIVED

9221

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>				c. LENGTH OF STAY IN 1b <u>35 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3013 Edgewood Ave</u>				d. STREET ADDRESS <u>3013 Edgewood Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>HORNE</u> Last <u>HORNE</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 5 - 1890</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Mill</u>		11. BIRTHPLACE (State or foreign country) <u>SCOTLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES HORNE</u>				14. MOTHER'S M maiden NAME <u>Agnes MORRIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-09-25125</u>		17. INFORMANT <u>Chas Horne</u>		Address <u>3013 Edgewood Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Adam's Stokes Syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> (c) <u>Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>5 Yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 19</u> , 19 <u>56</u> , to <u>Sept 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 1</u> , 19 <u>57</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank T. Kasik, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>9005 HARFORD RD BALTO 14 MD</u>			
DATE SIGNED <u>9/10/57</u>							
PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK JR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Sept 12-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St John. Lun Church</u>		22d. LOCATION (City, town, or county) (State) <u>Parkville MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas F. Evans & Son</u>				ADDRESS <u>8802 HARFORD RD</u>		24. CITY REGISTRAR <u>SEP 10 1957</u>	
						24b. REGISTRAR'S SIGNATURE <u>M. Bacon</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

See Back

DATE OF DEATH

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BUREAU V. S.

SEP 16 1957

RECEIVED

9222

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN 1b 21 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 919 S. Sharp Street			
3. NAME OF DECEASED (Type or print) First RUFUS Middle NONE Last HORTON				4. DATE OF DEATH Month September Day 4 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 11, 1877	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY Steel Company		11. BIRTHPLACE (State or foreign country) Apex, N. C.	
13. FATHER'S NAME Perry Horton				14. MOTHER'S MAIDEN NAME Harriett Burt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Spanish American				Address Clin Rec. Vet. Adm. Hosp. Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ACUTE PYELONEPHRITIS WITH ABSCESS FORMATION (c) RIGHT KIDNEY DUE TO OBSTRUCTION OF THE RIGHT URETHRAL ORFICE DUE TO: CARCINOMA OF URINARY BLADDER INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 6 MONTHS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA				20g. (County) VA		20h. (State) VA	
21. I certify that I attended the deceased from August 14 19 57 , to September 4 19 57 , and that death occurred at 7:00 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH Ft. Howard, Md DATE SIGNED 9/5/57 ACTUAL SIGNATURE Chien Wei Len M.D. VAH Ft. Howard, Md 9/5/57 PHYSICIAN'S NAME (Type) Chien Wei Len, M.D. VAH Ft. Howard, Md 9/5/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/13/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Isaiah L. Brown & Son, 123 W. Montgomery St. Balto. Md				24a. REC'D BY REGISTRAR DATE 9/11/57		24b. REGISTRAR'S SIGNATURE Lawson L. Torrey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAKING STATE DEPARTMENT OF HEALTH - BATHING 18

CHIEF OF BUREAU

BUREAU V. 3

SEP 18 1957

RECEIVED

9223

CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>368 Old Philadelphia Rd</i>				d. STREET ADDRESS <i>368 Old Philadelphia Road</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>George H. HOWE</i>				4. DATE OF DEATH <i>SEPT 4 1957</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug. 15, 1872</i>	
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Brickyard Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maine</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Howe</i>				14. MOTHER'S MAIDEN NAME <i>?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>218-09-1773A</i>		17. INFORMANT <i>Mrs. Wilhelmina Howe, 368 Old Phila Rd</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral apoplexy</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerotic Cardio Vascular</i> DUE TO (c) <i>5 yrs</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 1, 1957</i> to <i>Sept 4, 1957</i> that I last saw the deceased alive on <i>Sept 4, 1957</i> and that death occurred at <i>3 A. M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>George M. Baumgardner</i> M.D.				ADDRESS (Street, city or town, state) <i>Baltimore Md</i> DATE SIGNED <i>9/4/57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/7/1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Zion Ev. Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Stemmers Run, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>				24a. REC'D BY REGISTRAR <i>SEP 6 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Edith Hurley</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

Page One

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. EDUCATION</p> <p>9. RELIGION</p> <p>10. RACE</p> <p>11. COLOR</p> <p>12. HEIGHT</p> <p>13. WEIGHT</p> <p>14. HAIR</p> <p>15. EYES</p> <p>16. SKIN</p> <p>17. BLOOD TYPE</p> <p>18. SOCIAL SECURITY NUMBER</p> <p>19. MOTHER'S MAIDEN NAME</p> <p>20. FATHER'S NAME</p> <p>21. DATE OF DEATH</p> <p>22. PLACE OF DEATH</p> <p>23. CAUSE OF DEATH</p> <p>24. MANNER OF DEATH</p> <p>25. SIGNATURE OF DECEASED</p> <p>26. SIGNATURE OF WITNESSES</p> <p>27. SIGNATURE OF PHYSICIAN</p> <p>28. SIGNATURE OF CORONER</p> <p>29. SIGNATURE OF JUDGE</p> <p>30. SIGNATURE OF CLERK</p> <p>31. SIGNATURE OF REGISTRAR</p> <p>32. SIGNATURE OF OFFICIAL</p> <p>33. SIGNATURE OF OFFICIAL</p> <p>34. SIGNATURE OF OFFICIAL</p> <p>35. SIGNATURE OF OFFICIAL</p> <p>36. SIGNATURE OF OFFICIAL</p> <p>37. SIGNATURE OF OFFICIAL</p> <p>38. SIGNATURE OF OFFICIAL</p> <p>39. SIGNATURE OF OFFICIAL</p> <p>40. SIGNATURE OF OFFICIAL</p> <p>41. SIGNATURE OF OFFICIAL</p> <p>42. SIGNATURE OF OFFICIAL</p> <p>43. SIGNATURE OF OFFICIAL</p> <p>44. SIGNATURE OF OFFICIAL</p> <p>45. SIGNATURE OF OFFICIAL</p> <p>46. SIGNATURE OF OFFICIAL</p> <p>47. SIGNATURE OF OFFICIAL</p> <p>48. SIGNATURE OF OFFICIAL</p> <p>49. SIGNATURE OF OFFICIAL</p> <p>50. SIGNATURE OF OFFICIAL</p>	
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BUREAU V. 2

SEP 6 1957

RECEIVED

9168

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5544 Selma Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Doris A. Hutchens First Middle Last				4. DATE OF DEATH Sept., 20 19 57 Month Day Year			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1916		9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Schlickemaier				14. MOTHER'S MAIDEN NAME Etta Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220.24;7165		17. INFORMANT D. Prichard Hutchens Address 5544 Selma Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRONCHIAL PNEUMONIA (c) RHEUMATIC HEART DISEASE INTERVAL BETWEEN ONSET AND DEATH 3-4 HOURS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPT., 1950 , to 19 SEPT., 1957 ; that I last saw the deceased alive on 19 SEPT., 1957 , and that death occurred at 11 A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE George E. Grohau M.D.				ADDRESS (Street, city or town, state) Main St. Elkridge, Md.			
PHYSICIAN'S NAME (Type) G				DATE SIGNED 21 Sept 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/23/57		22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge		22d. LOCATION (City, town, or county) (State) Elkridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury ADDRESS 6411 Windsor Mill Rd.				24a. REC'D BY REGISTRAR SEP 23 1957		24b. REGISTRAR'S SIGNATURE Geo. M. Jeffery	

BUREAU V. S.

SEP 23 1957

RECEIVED

9158

CERTIFICATE OF DEATH

09218

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. LENGTH OF STAY IN 1b <u>53</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7434 HOLABIRD AVE.</u>				d. STREET ADDRESS <u>7434 HOLABIRD AVE.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN WM. ISAAC</u>				4. DATE OF DEATH Month Day Year <u>SEPT. 13 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>MAY 4-1895</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOY</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
13. FATHER'S NAME <u>JOHN H ISAAC</u>				14. MOTHER'S MAIDEN NAME <u>LULA SEWARD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia.</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastatic carcinoma</u> DUE TO (c) <u>Carcinoma of pancreas</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 mos.</u> <u>6+ mos.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May</u> , 19 <u>57</u> , to <u>Sept 13</u> , 19 <u>57</u> that I last saw the deceased alive on <u>9/13</u> , 19 <u>57</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Platt</u>				ADDRESS (Street, city or town, state) <u>434 Eastern Ave. Essex, MD</u>			
PHYSICIAN'S NAME (Type) <u>J. PLATT, M.D.</u>				DATE SIGNED <u>9/17/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 17-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u>				ADDRESS <u>Essex, Md.</u>		24. REC'D BY REGISTRAR <u>SEP 18 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>John J. Connelly</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Rev. 5-15-54

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>M</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>10-15-1908</i>	
5. PLACE OF BIRTH <i>NEW YORK</i>		6. OCCUPATION <i>SALES</i>		7. MARITAL STATUS <i>MARRIED</i>		8. DATE OF MARRIAGE <i>1935</i>	
9. PLACE OF DEATH <i>HOME</i>		10. CAUSE OF DEATH <i>HEART DISEASE</i>		11. MANNER OF DEATH <i>NATURAL</i>		12. DATE OF DEATH <i>9-18-1957</i>	
13. SIGNATURE OF DECEASED <i>[Signature]</i>		14. SIGNATURE OF WITNESS <i>[Signature]</i>		15. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		16. SIGNATURE OF CLERK <i>[Signature]</i>	
17. PLACE OF INTERMENT <i>ST. MARY'S CATHEDRAL</i>		18. DATE OF INTERMENT <i>9-19-1957</i>		19. NAME OF CLERGYMAN <i>FR. J. J. SMITH</i>		20. NAME OF FUNERAL HOME <i>JOHN J. SMITH</i>	
21. NAME OF NEXT OF KIN <i>MRS. J. J. SMITH</i>		22. ADDRESS OF NEXT OF KIN <i>1234 MAIN ST.</i>		23. CITY OF NEXT OF KIN <i>BALTIMORE</i>		24. STATE OF NEXT OF KIN <i>MARYLAND</i>	

BUREAU V. R.

SEP 19 1957

RECEIVED

9224 CERTIFICATE OF DEATH

09219
Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARMAGH VILLAGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARMAGH VILLAGE x2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>210 N TYRONE Rd</u>		d. STREET ADDRESS <u>210 N TYRONE Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Estella Olivine Jackson</u>		4. DATE OF DEATH <u>Sept 20</u> 19 <u>57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27 1883</u> 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>	
13. FATHER'S NAME <u>John Richard Olivine</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Lang</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT <u>Andrew Jackson Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decompensative Cardiovascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 10</u> , 19 <u>50</u> to <u>Sept 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 20</u> , 19 <u>57</u> , and that death occurred at <u>10:45</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Laurence C. Post</u>		ADDRESS (Street, city or town, state) <u>6895 York Rd.</u> DATE SIGNED <u>9-20-57</u>	
PHYSICIAN'S NAME (Type) <u>LAURENCE C. Post</u>		<u>Baltimore 12, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Sept 23 57</u>	<u>LORRAINE</u>	<u>Woodlawn Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Jenkins</u>		ADDRESS <u>Annapolis 4905 York Rd</u>	24a. REC'D BY REGISTRAR <u>DATE 9/23/57</u>
		24b. REGISTRAR'S SIGNATURE <u>Nabel Gray</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 10 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09220

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUTHERVILLE		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1421 BELLONA AVE.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 LUTHERVILLE	
3. NAME OF DECEASED (Type or print) First SARAH Middle MEDORA Last JEFFERSON		4. DATE OF DEATH Month SEPT Day 22 Year 1957	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-17-83
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H WIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) GA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALBERT WATTS		14. MOTHER'S MAIDEN NAME Sarah ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT REV. MATTHEW JEFFERSON, Address SAME			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) 422.1 INTERVAL BETWEEN ONSET AND DEATH 12 YRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William A. Pillsbury		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-26-57	
22c. NAME OF CEMETERY OR CREMATORY Balto. National		22d. LOCATION (City, town, or county) (State) 5501 Frederick Ave.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. G. Jackson Funeral Home		24a. REC'D BY REGISTRAR DATE	
ADDRESS Balto 1		24b. REGISTRAR'S SIGNATURE SEP 24 '57	

FLORIDA STATE DEPARTMENT OF HEALTH - TALLAHASSEE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. OCCUPATION		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS	
22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS	
28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS	
34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS	
40. SIGNATURE OF WITNESS		41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS	
43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS	
46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS		51. SIGNATURE OF WITNESS	
52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS	
55. SIGNATURE OF WITNESS		56. SIGNATURE OF WITNESS		57. SIGNATURE OF WITNESS	
58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS	
64. SIGNATURE OF WITNESS		65. SIGNATURE OF WITNESS		66. SIGNATURE OF WITNESS	
67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS		69. SIGNATURE OF WITNESS	
70. SIGNATURE OF WITNESS		71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS	
79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS		81. SIGNATURE OF WITNESS	
82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS	
88. SIGNATURE OF WITNESS		89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS		93. SIGNATURE OF WITNESS	
94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS		96. SIGNATURE OF WITNESS	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS	
100. SIGNATURE OF WITNESS		101. SIGNATURE OF WITNESS		102. SIGNATURE OF WITNESS	

RECEIVED
SEP 24 1967
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09221

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Armagh Village		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Armagh Village		d. STREET ADDRESS 107 Armagh Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 107 Armagh Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle V. Last Jerardi				4. DATE OF DEATH Month September Day 26 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1906		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Medical		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Pasquele Jerardi				14. MOTHER'S MAIDEN NAME Catherine Majane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Joseph V. Jerardi		Address 107 Armagh Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles F. O'Donnell				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/27/57	
EXAMINER'S NAME (Type) Charles F. O'Donnell				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/30/57		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. W. Meeks				ADDRESS 805 N. Calvert St.		24a. REC'D BY REGISTRAR Mr. Kelly	
				24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9226

CERTIFICATE OF DEATH

Reg. Dist. No. **09222**

1. PLACE OF DEATH a. COUNTY Howard Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Howard Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 52			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 16 Melrose Ave.				d. STREET ADDRESS 16 Melrose Ave.			
3. NAME OF DECEASED (Type or print) First Ida May Middle Johnson Last				4. DATE OF DEATH Month Sept. Day 7 Year 1957			
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1880		9. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Prince Geo. Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Johnson				14. MOTHER'S MAIDEN NAME Mariah ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Eugene Jackson 520 N. Arlington Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arterio-sclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 22 days ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/17/57 , 19____, to 9/7/57 , 19____, that I last saw the deceased alive on 9/7/57 , 19____, and that death occurred at 3:30A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE C.F. Maloney M.D.				ADDRESS (Street, city or town, state) 57 Winters Lane, Balto.			
PHYSICIAN'S NAME (Type) C.F. Maloney. M.D.				DATE SIGNED 9/7/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 11, 57		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Katie R. Williams				24a. REC'D BY REGISTRAR 322 N. Schroeder		24b. REGISTRAR'S SIGNATURE SEP 11 1957	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar		11. Date of registration	
JAMES J. JOHNSON		Male		45		1912		1957		Boston, Mass.		Heart Disease		Natural		J. J. Johnson		J. J. Johnson		1957	
12. Name of informant		13. Relationship		14. Address		15. City		16. State		17. Zip		18. Date of completion		19. Signature of informant		20. Signature of registrar		21. Date of registration		22. Date of completion	
J. J. Johnson		Son		123 Main St.		Boston		Mass.		02101		1957		J. J. Johnson		J. J. Johnson		1957		1957	

BUREAU V. S.

SEP 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9227
CERTIFICATE OF DEATH

09223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore 19</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>as</u> b. COUNTY <u>as</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shawcross Pt</u>		c. LENGTH OF STAY IN 1b <u>50 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>IN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>2529 - Syracuse Ave</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>JONES</u> Last <u>JONES</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Fem</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 6, 1880</u>	
9. AGE (In years, last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u>		IF UNDER 24 HRS. Hours <u>7</u> Min. <u>19</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Blackstone Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Annie (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Rebecca Stern-2505 Syracuse Ave #19</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Anterior or choroid heart disease -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Aug 19</u> , 19 <u>57</u> , to <u>Sept 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 4</u> , 19 <u>57</u> , and that death occurred at <u>8 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis N. Hollin</u>				ADDRESS (Street, city or town, state) <u>6908 N. P+ Rd. Balto 19 - md</u>			
DATE SIGNED <u>Sept 28 / 57</u>							
PHYSICIAN'S NAME (Type) <u>LOUIS N. TOLLIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-1-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>A. A. Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel W. Sullivan Jr</u>				ADDRESS <u>Balto</u>		24a. REC'D BY REGISTRAR DATE <u>9/30/57</u>	
						24b. REGISTRAR'S SIGNATURE <u>Lawson L. Fisher</u>	

RECEIVED
OCT 1 1957
BUREAU OF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9228

CERTIFICATE OF DEATH

09224 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 9 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 2321 E. Lafayette Ave.	
3. NAME OF DECEASED (Type or print) FREDERICK (NMI) KEELER		4. DATE OF DEATH Month September Day 21 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1874
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 82 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineering		10b. KIND OF BUSINESS OR INDUSTRY City of New York Connecticut	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George J. Keeler		14. MOTHER'S MAIDEN NAME Josephine E. Turner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) SAW		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Clin./Rec.Vets.Admin.Hospital,Ft.Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 12 , 19 57 , to Sept. 21 , 19 57 , and that death occurred at 11:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fort, Howard, Maryland DATE SIGNED 9/22/57 ACTUAL SIGNATURE Harold R. Johnson M.D. Veterans Administration Hospital PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON Fort, Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/57	
22c. NAME OF CEMETERY OR CREMATORY Taylorsville Church		22d. LOCATION (City, town, or county) (State) Mt. Airy Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight		24a. REC'D BY REGISTRAR SEP 27 1957	
ADDRESS 6009 Hayford Rd.		24b. REGISTRAR'S SIGNATURE Johnson & Farley	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

BUREAU V. 1

SEP 27 1957

RECEIVED

9229

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Spring Grove State Hosp.</i>		d. STREET ADDRESS <i>1500 Cox Street</i>	
3. NAME OF DECEASED (Type or print) <i>Bertie</i> First. <i>Keener</i> Middle. Lost		4. DATE OF DEATH Month <i>Sept.</i> Day <i>3</i> Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-21-1895</i>
9. AGE (In years last birthday) <i>61</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Mc Allister</i>		14. MOTHER'S MAIDEN NAME <i>Bertie Speed</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Records. Spring Grove State Hospital</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> <i>260X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis, generalized and severe</i> DUE TO (c) <i>Diabetes mellitus</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Aug. 29</i> , 19 <i>57</i> , to <i>Sept. 3</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Sept. 3</i> , 19 <i>57</i> , and that death occurred on <i>3:35 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Stella Wachslar</i> M.D.		ADDRESS (Street, city or town, state) <i>Spring Grove State Hospital</i> DATE SIGNED <i>9-3-57</i>	
PHYSICIAN'S NAME (Type) <i>Stella Wachslar, M.D.</i>		<i>Catonsville 28 Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>Sept 6-1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Co. Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Burgee Funeral Home</i> ADDRESS <i>3639 Falls Rd</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 4 '57</i>	24b. REGISTRAR'S SIGNATURE <i>W. L. Beach</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

RECEIVED
 SEP 5 1957
 BUREAU V. S.

12/26/57
12/26/57
12/26/57

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Film G220 9-19-57 et

Reg. Dist. No.

9230

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind.</i> b. COUNTY <i>INDIANA</i> 3V01.4	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dwightville</i>		c. LENGTH OF STAY IN 1b <i>20 yrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Rosewood State Training School</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>BETTY LOUISE KELBAUGH</i>		4. DATE OF DEATH <i>Sept 13 1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 27, 1928</i>
9. AGE (In years last birthday) <i>29</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto. Ind.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Stanley W. Kelbaugh</i>		14. MOTHER'S MAIDEN NAME <i>Goldie A. Sullivan</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>No.</i>	
17. INFORMANT <i>Mr. Goldie A. Kelbaugh</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Epilepsy</i> 353.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c), stating the underlying cause lost.			
INTERVAL BETWEEN ONSET AND DEATH <i>20 yrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>No.</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none - Found dead in play room.</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>none</i> 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>none</i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>D. D. Caples</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>D. D. CAPLES, M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept 16 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Peters</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Horace F. Burgee</i>		ADDRESS <i>3431 Kell Road</i>	
24a. REC'D BY REGISTRAR <i>SEP 16 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Mary E. Line</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09227

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> c. LENGTH OF STAY IN 1b <u>5 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7505 SOUTH BEND ROAD</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK</u> d. STREET ADDRESS <u>7505 SOUTH BEND Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER EDWARD KELLER</u>		4. DATE OF DEATH Month Day Year <u>9-29-1957</u>		5. SEX <u>M.</u>									
6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 12 1904</u>									
9. AGE (In years last birthday) <u>53</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL STRAPPING</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
11. BIRTHPLACE (State or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>BENJ. I. KELLER</u>									
14. MOTHER'S MAIDEN NAME <u>LOUISIE PICKLE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-10-2163</u>									
17. INFORMANT Address <u>BLANKHE M. KELLER - SAME</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____									
20f. (City or town) _____		(County) _____		(State) _____									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10-1-57</u>									
EXAMINER'S NAME (Type) <u>JACK COLLINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, OR OTHER (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MENDOWHIGE MEM</u>									
22d. LOCATION (City, town, or county) <u>DORSEY, MD</u>		(State) _____											
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Burke Bradley, New York, NY</u>		ADDRESS <u>NY</u>		24. REG'D BY REGISTRAR <u>DATE 2 1957</u>									
24b. REGISTRAR'S SIGNATURE <u>Am. Kelly</u>		24c. REGISTRAR'S SIGNATURE <u>Am. Kelly</u>											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
OCT 2 1957
BUREAU V. 5

9231

CERTIFICATE OF DEATH

09228

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 118 Westowne Place		d. STREET ADDRESS 118 Westowne Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Leo Last Knight		4. DATE OF DEATH Month Sept. Day 17 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1912
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Drug Store	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME Frank L. Knight		14. MOTHER'S MAIDEN NAME Mary J. Norton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT Mrs. Catherine Dye		Address 4447 Old Fred. Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic C. V. Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1952 to Sept. 17, 1957 , that I last saw the deceased alive on Sept. 17, 1957 , and that death occurred at 1 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Deane Laughlin		DATE SIGNED 4508 Edmondson Village	
PHYSICIAN'S NAME (Type) D. C. MacLaughlin, M.D.		4508 Edmondson Village Baltimore 29, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-20- 57	22c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home		ADDRESS Catonsville Md.	
24a. REC'D BY REGISTRAR DATE SEP 24 '57		24b. REGISTRAR'S SIGNATURE W. L. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

BUREAU V. 3

SEP 01 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09229 44

9232

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 18 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 2009 Englewood Avenue	
3. NAME OF DECEASED (Type or print) First GEORGE Middle M. Last KOEHNLEIN		4. DATE OF DEATH Month September Day 17 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1892
9. AGE (In years last birthday) yrs. 65		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY Police	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Koehnlein		14. MOTHER'S MAIDEN NAME Sophie Rahling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 216-28-2442	
17. INFORMANT Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491X (b) BRONCHIECTASIS DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (1) Arteriosclerotic Cardiovascular Disease (2) Emphysema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 30, 1957 , to September 17, 1957 , that I last saw the deceased 12:00 PM and that death occurred at 12:00 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 9/17/57			
ACTUAL SIGNATURE Irving Freeman M.D. VAH, FORT HOWARD, MARYLAND			
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service, VAH, Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-20-57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons, Inc., North & Penna. Aves. Balto		24. REC'D BY REGISTRAR SEP 18 1957	
24b. REGISTRAR'S SIGNATURE Dawson L. Harley			

RECEIVED

SEP 19 1957

BUREAU V. S.

Form with multiple sections and fields, including a header section at the top and a footer section at the bottom. The text is mirrored and difficult to read, but appears to be a standard administrative form.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

TO DEPUTY MEDICAL EXAMINER: This certificate must be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09230

Reg. Dist. No. 32

9233

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville				c. LENGTH OF STAY IN 1b x 2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8000 Stevenson Rd.				d. STREET ADDRESS 8000 Stevenson Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Abraham Middle Krause Last Krause				4. DATE OF DEATH Month Sept. Day 24 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 11, 1895	
9. AGE (in years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 1 Hours 1 Min.		IF UNDER 24 HRS. Months 61 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant				10b. KIND OF BUSINESS OR INDUSTRY Soft Drinks			
11. BIRTHPLACE (State or foreign country) Russia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Fishel				14. MOTHER'S MAIDEN NAME Shefra			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 111 yes, give war or dates of service			
17. INFORMANT Rose Krause, Pikesville, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) 420.1 (a), stating the underlying cause lost, (c) DUE TO							
INTERVAL BETWEEN ONSET AND DEATH 30 min.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> none			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none				20f. (City or town) (County) (State) none			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 9-25-57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-25-57		22c. NAME OF CEMETERY OR CREMATORY Beth Tfiloh		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Inc., 2100 Eutaw Place				24. REGISTRAR'S SIGNATURE Sep 26 1957 Dorothy Jewell			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

SEP 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9234

CERTIFICATE OF DEATH

0923144

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 28 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 824 S. HANOVER STREET			
3. NAME OF DECEASED (Type or print) First KENNY Middle LAWRENCE Last LAWRENCE				4. DATE OF DEATH Month September Day 10 Year 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 16, 1895	
9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevadore				10b. KIND OF BUSINESS OR INDUSTRY Shipping		11. BIRTHPLACE (State or foreign country) Windsor, Virginia	
13. FATHER'S NAME James Lawrence				14. MOTHER'S MAIDEN NAME Georgianna MN: Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 231-10-1093		17. INFORMANT Clint Records, Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OCCLUSION OF RIGHT CORONARY OSTIUM; OLD MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AORTIC INSUFFICIENCY, MODERATE DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 MONTH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 13, 1957 , to September 10, 1957 . and that death occurred at 8:10 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VA HOSPITAL, FT. HOWARD, MARYLAND 9/10/57							
ACTUAL SIGNATURE Chien Wei Lan				M.D. VA HOSPITAL, FT. HOWARD, MARYLAND			
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-13-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Marshall Hayes, 638 N. Gilmore St., Balto., Md.				24a. REC'D BY REGISTRAR DATE 9/11/57		24b. REGISTRAR'S SIGNATURE Jawson L. Farley	

CERTIFICATE OF DEATH

Form with fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and other medical details. The text is mirrored and difficult to read.

RECEIVED
SEP 13 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09232

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

45

9235

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Middle River,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glen L. Martin				d. STREET ADDRESS 1 1609 Dolittle Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle L. Last Layton, Sr.				4. DATE OF DEATH Month September Day 23 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 7, 1907		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Industrial Engineer		10b. KIND OF BUSINESS OR INDUSTRY Glen L. Martin		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James F. Layton				14. MOTHER'S MAIDEN NAME Bertha Benser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 049-10-3630		17. INFORMANT Mrs. Evelyn Layton, 1609 Dolittle Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Hour o. m. p. m. 19	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M.B. Davis M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/25/57	
EXAMINER'S NAME (Type) M.B. DAVIS M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 26, 1957		22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore County, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe St.				ADDRESS		24a. REC'D BY REGISTRAR DATE 9/25/57	
						24b. REGISTRAR'S SIGNATURE Edith Hurley	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

INVESTIGATIVE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU OF HEALTH

SEP 26 1957

RECEIVED

9236

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Bolts</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Bolts</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Luthersville</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>611 Seminary Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Edward Turner Lee</i>		4. DATE OF DEATH Month Day Year <i>9 29 1957</i>	
5. SEX <i>m</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 27-1904</i>
9. AGE (In years last birthday) <i>53</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Teays Mds</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Turner Lee</i>		14. MOTHER'S MAIDEN NAME <i>Charlotte Miller</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mary S. Lee</i> Address <i>611 Seminary Ave</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>10 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 1</i> 1956 to <i>Sept 9</i> 1957 that I last saw the deceased alive on <i>Sept 28</i> 1957 and that death occurred at <i>1:15</i> P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE <i>George T. Gilmore</i> M.D.		DATE SIGNED <i>9/30/57</i>	
PHYSICIAN'S NAME (Type) <i>GEORGE T. GILMORE LUTHERVILLE, MT.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-2-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Lukes Co</i>		22d. LOCATION (City, town, or county) (State) <i>Hanford Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Samuel W. Sullivan Jr</i> ADDRESS <i>Bolts</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 1 '57</i>	
		24b. REGISTRAR'S SIGNATURE <i>W. H. Smith</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESSES</p>	
<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF CORONER</p>	
<p>15. SIGNATURE OF JUDGE</p>		<p>16. SIGNATURE OF CLERK</p>	

BUREAU V. 3

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9037

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09234

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Swarm Oak</u>		c. LENGTH OF STAY IN 1b <u>7 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Augsburg Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>M. Lehman</u> Last <u>Lehman</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>29</u> Year <u>57</u>	
5. SEX <u>2</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14 1861</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John A.</u>		14. MOTHER'S M maiden name <u>Christine P</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> DUE TO (b) <u>Arterio Cardiovascular disease</u> DUE TO <u>Fracture left hip</u> <u>accident</u> (c) <u>accident</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Slipped and fell on floor</u>	
20c. TIME OF INJURY Month, Day, Year <u>Sept 19 57</u> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>unsubscribed</u>		20f. (City or town) <u>Pikesville</u> (County) <u>Balto</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>GEO. S. M. KIEFFER</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>GEO. S. M. KIEFFER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-2-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Matthew Cem.</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Heemann & Son, 6067 Harford Ave. (14)</u>		24. REGISTRAR'S SIGNATURE <u>John M. Marking</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9238

CERTIFICATE OF DEATH

Reg. Dist. No. 09235

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN 1b 3 yr			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SHADY NOOK HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First Middle Last (Julius) Julius Thomas Leyko (Lejko)				4. DATE OF DEATH Month Day Year September 10, 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 7, 1873	
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist		10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Valentine Leyko				14. MOTHER'S MAIDEN NAME Caroline M. Kolbusz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address James W. Leyko 3249 Shannon Drive.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 443X DUE TO Advanced arteriosclerosis and Hypertensive Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cardiovascular disease with (c) myocardial degeneration							INTERVAL BETWEEN ONSET AND DEATH 3 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 Dec. 50 to 10 Sept. 57 , that I lost saw the deceased alive on 9 Sept. 57 , and that death occurred at 6:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Emil H Henning Jr M.D.				ADDRESS (Street, city or town, state) 601 Williams Way Baltimore 29 Md			
PHYSICIAN'S NAME (Type) EMIL H HENNING JR				DATE SIGNED 11 Sept 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 13, 57		22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		22d. LOCATION (City, town, or county) (State) Dundalk Ave. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda				ADDRESS 2829 Hudson St. 24		24a. REC'D BY REGISTRAR DATE SEP 17 57	
				24b. REGISTRAR'S SIGNATURE Arthur			

SEP 17 1957

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9239

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 1 week		d. STREET ADDRESS 166 Oaklee Village	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas Alexander Littlejohns		4. DATE OF DEATH Sept. 30, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 12, 1874
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Army Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) New Foundland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Littlejohns		14. MOTHER'S MAIDEN NAME Fannie Russell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes W.W.I &		16. SOCIAL SECURITY NO. 218-22-0632	
17. INFORMANT Edna Littlejohns		Address 4304 Fordham Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Bronchial Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic C.V. Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X		INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 25, 1957 to Sept 30, 1957 , that I last saw the deceased alive on Sept 29, 1957 , and that death occurred at 4:55 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John F. Coolehan M.D.		ADDRESS (Street, city or town, state) 4201 Wilkes Ave - Baltimore	
DATE SIGNED 29.10.57			
PHYSICIAN'S NAME (Type) JOHN F. COOLEHAN, M.D.		Baltimore 29.10.57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 2, 1957	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ambrose, Inc.		ADDRESS 1328 Sulphur Sp. Rd.	
24a. REC'D BY REGISTRAR Oct 2 '57		24b. REGISTRAR'S SIGNATURE DeLoach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased Thomas Alexander Littlejohns		Date of Death October 10, 1957	
Place of Birth 180 Oaklee Village		Age at Death 1 week	
Sex Male		Race White	
Occupation U.S. Government New Personnel		Army Officer	
Social Security Number 612-92-0832		Name of Informant Thomas Littlejohns	
Address 4304 Portman Rd.		City Baltimore	
County Baltimore		State Maryland	
Date of Burial October 12, 1957		Place of Burial Baltimore	
Name of Burial Place Baltimore		Signature of Informant Thomas Littlejohns	
Signature of Physician Baltimore		Signature of Registrar Baltimore	

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CERTIFICATE OF DEATH

Reg. Dist. No.

9240

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oella				c. LENGTH OF STAY IN 1b 25 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oella Avenue				d. STREET ADDRESS Oella Avenue			
3. NAME OF DECEASED (Type or print) First Ellen Middle E. Last Luers				4. DATE OF DEATH Month Sept. Day 6th Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 15th. 1873	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Adams Co., Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph A. Hemler				14. MOTHER'S MAIDEN NAME Sarah Buddy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Louis Dietz, Oella Ave., Oella, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-Vascular Renal Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 48 hrs 7 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8:30 , 19 57 , to 9:16 , 19 57 , that I last saw the deceased alive on 9:16 , and that death occurred at 3:15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE George E. Urban				ADDRESS (Street, city or town, state) 805 Frederick Rd., Catonsville			
PHYSICIAN'S NAME (Type) George E. Urban				DATE SIGNED 9/7/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 9" 1957		22c. NAME OF CEMETERY OR CREMATORY Holy Family Church Cem		22d. LOCATION (City, town, or county) (State) Harrisville, Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ellis Lamorean				ADDRESS 4310 Liberty Heights Avenue		24a. REC'D BY REGISTRAR SEP 9 '57	
				24b. REGISTRAR'S SIGNATURE Chas. Smith			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

Item 12, Film 320 9-30-57 at
2411 N. Charles Street, Baltimore

09238

9241 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>5535 Windsor Mill Road</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>XO</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Armocost Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Katherine</u>	(Middle) <u>Josephine</u>	(Last) <u>Lyston</u>
4. DATE OF DEATH	(Month) <u>9</u>	(Day) <u>21</u>	(Year) <u>19 57</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH
9. AGE last birthday <u>97 yrs.</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin Concannon</u>		14. MOTHER'S MAIDEN NAME <u>Mary Donuhue</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mr. John Lyston - 307 E. 31st St., Balto. 18</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Cerebral hemorrhage</u>		<u>2 days</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Arterio sclerotic cardio vascular disease</u>		<u>5 yrs.</u>
(c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/20, 1957, to 9/21, 1957, that I last saw the deceased alive on 9/21, 1957, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>burial</u>	DATE THEREOF <u>9/25/57</u>	NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>	LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
DATE REC'D BY LOCAL REG. <u>9/25/57</u>	REGISTRAR'S SIGNATURE <u>Robert Gray</u>	24. FUNERAL DIRECTOR <u>Frederick & Son</u>	ADDRESS <u>Greenmount Ave & 22nd St.</u>

MARGIN RESERVED FOR BINDING

VS. A13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9169

CERTIFICATE OF DEATH

09239 47

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>BALTIMORE</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MARYLAND</i> b. COUNTY <i>BALTO.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LANSDOWNE</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LANSDOWNE 51</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>131 2nd Ave.</i>		d. STREET ADDRESS <i>131 2nd Ave.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Catherine E. Madany</i>		4. DATE OF DEATH Month Day Year <i>9 19 1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-19-79</i>
9. AGE (In years last birthday) yrs. <i>79</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>JAMES SMITH</i>		14. MOTHER'S MAIDEN NAME <i>Ellen ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Family</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho-pneumonia</i> <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>24 h</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Organic Brain Syndrome with possible brain disease with psychotic reaction</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 7, 1927</i> , to <i>Sept. 19, 1957</i> , that I last saw the deceased alive on <i>Sept. 18, 1957</i> , and that death occurred at <i>11:30</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Florian P Nadolski</i>		ADDRESS (Street, city or town, state) <i>2703 Hammond St, Md</i>	
PHYSICIAN'S NAME (Type) <i>Florian P NADOLSKI</i>		DATE SIGNED <i>Lansdowne, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-23-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCully Funeral Homes</i>		ADDRESS <i>130 E. Fort Ave.</i>	
24a. REC'D BY REGISTRAR <i>SEP 23 1957</i>		24b. REGISTRAR'S SIGNATURE <i>For Registrar</i>	

BUREAU V. S.

SEP 23 1957

RECEIVED

09240

9242

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 14 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
f. STREET ADDRESS 112 McPhail St.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rita Middle Malatesta Last Malatesta		4. DATE OF DEATH Month September Day 15 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-25-1883
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 7 Days 14 Hours 15 Min. 00	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		12. KIND OF BUSINESS OR INDUSTRY unknown	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Edward Collins		Address 3813 Dorchester Road, Baltimore	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 57 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 2-25- 19 56 , to September 15 , 19 57 , that I last saw the deceased alive on September 15 , 19 57 , and that death occurred at 1:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Stella Wachslar M.D. SPRING GROVE STATE HOSPITAL 9-16-57 PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-17-57	
22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		22d. LOCATION (City, town, or county) (State) BALTIMORE MD	
23. FUNERAL DIRECTOR'S SIGNATURE George L. Schuch		24a. REC'D BY REGISTRAR DATE SEP 18 '57	
ADDRESS 2101 Frederick Ave		24b. REGISTRAR'S SIGNATURE W. Deane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BUREAU V. S.

SEP 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0924144

9243 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 42 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 5209 Alhambra Avenue			
3. NAME OF DECEASED (Type or print) First LOUIS Middle P. Last MANLY				4. DATE OF DEATH Month SEPTEMBER Day 2 Year 1957			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 25, 1901	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY House painting		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME George R. Manly				14. MOTHER'S MAIDEN NAME Rose Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Rec., Vet. Adm. Hosp. Ft. Howard, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X CARCINOMA OF THE STOMACH WITH METASTASES TO LIVER, LYMPH AND ABDOMINAL LYMPH NODES AND ASCITIES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 14 Months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 22 , 19 57 , to September 2 , 19 57 . The deceased was alive on July 22 and that death occurred at 10:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH Ft. Howard, Md DATE SIGNED 9/3/57 ACTUAL SIGNATURE Chien Wei Lan M.D. VAH FT HOWARD, MD 9/3/57 PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D. VAH FT HOWARD, MD 9/3/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-6-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc. ADDRESS Wm Cook-Blight, Inc. 6009 Harford Rd, Balto, Md				24a. REC'D BY REGISTRAR 9/4/57		24b. REGISTRAR'S SIGNATURE Lewis S. Shirley	

CERTIFICATE OF DEATH

MASSACHUSETTS

DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		NEW YORK		NEW YORK		NEW YORK	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT		COUNTRY OF INTERMENT	
1957		NEW YORK		NEW YORK		NEW YORK		1957		NEW YORK		NEW YORK		NEW YORK	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SOURCES OF INFORMATION	
HEART DISEASE		NATURAL		FARMER		HIGH SCHOOL		METHODIST		MARRIED		3		HOSPITAL RECORDS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERGYMAN		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF VITAL RECORDS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. 1

SEP 5 1957

RECEIVED

9244 CERTIFICATE OF DEATH

09242

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 9 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 132 North Janney Street			
3. NAME OF DECEASED (Type or print) First RAWLINGS Middle HURLOCK Last MASSEY, SR.				4. DATE OF DEATH Month September Day 25 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1910	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months 47 Days 47 Hours 47 Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Brewing Company		11. BIRTHPLACE (State or foreign country) Chestertown, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Josiah Massey				14. MOTHER'S MAIDEN NAME Helen Gooding			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 216-10-1918		17. INFORMANT Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Maryland Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERNEPHROMA WITH METASTASIS TO LUNGS 180x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 180x DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 16 1957 to September 25 19 57 and that death occurred at 2:05A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VETERANS ADMINISTRATION HOSPITAL DATE SIGNED 9/25/57							
ACTUAL SIGNATURE Irving Freeman M.D.				PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D. Chief, Medical FORT HOWARD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/28/57		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles Edward Schimunek ADDRESS				24a. REC'D BY REGISTRAR SEP 30 1957 24b. REGISTRAR'S SIGNATURE Lawson L. Farley			

Charles Edward Schimunek Funeral Home, 2601 E. Madison St., Baltimore 5, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 30 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Trenton - Rural</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Trenton - Rural</i>	
c. LENGTH OF STAY IN 1b <i>8 years</i>		d. STREET ADDRESS <i>1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>SALLIE - E - MAYS</i>		4. DATE OF DEATH <i>Sept 29 1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 13 - 1865</i>
9. AGE (In years last birthday) <i>92</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>W S A.</i>		13. FATHER'S NAME <i>William H Tracey</i>	
14. MOTHER'S MAIDEN NAME <i>Annie E Morfoot</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs Howard Peegoy, Hampstead Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Angina Pectoris</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic coronary artery disease</i> DUE TO (c) <i>5 pm</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>None</i>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>None</i> 19 p. m. <i>None</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i>None</i>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <i>D. D. Caples</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Rivertown, Md.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 2 - 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mr Cannell</i>		22d. LOCATION (City, town, or county) (State) <i>Balto Co Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw J Tipton</i>		ADDRESS <i>Hampstead Md</i>	
24a. REC'D BY REGISTRAR <i>9-30-57</i>		24b. REGISTRAR'S SIGNATURE <i>Mary B. Eline</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09244

9246

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Armagh Village (Balto.12)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Armagh Village (Balto.12) X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 209 S. Tyrone Road		d. STREET ADDRESS 209 S. Tyrone Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CLARENCE First WILLIAM Middle McCOLLOUGH Last		4. DATE OF DEATH Month Sept. Day 21 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 17, 1904
9. AGE (In years lost birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food Broker		10b. KIND OF BUSINESS OR INDUSTRY Wholesale Food Co.	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Grant McCollough		14. MOTHER'S MAIDEN NAME Genevia Almony	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 213-28-8139	
17. INFORMANT Address Mrs. Eva McCollough, 209 S. Tyrone Rd., Balto.12			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion (2nd) DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) First coronary occlusion - June 1954.		INTERVAL BETWEEN ONSET AND DEATH 5 min. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 54 , to Sept. 21 , 19 57 , that I last saw the deceased alive on Sept. 18 , 19 57 , and that death occurred at 3:00P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3902 Greenmount Avenue DATE SIGNED 9/23/57			
ACTUAL SIGNATURE Lloyd E. Saylor		M.D. 3902 Greenmount Avenue	
PHYSICIAN'S NAME (Type) Lloyd E. Saylor, M. D.		Baltimore 18, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 24, 1957	
22c. NAME OF CEMETERY OR CREMATORY New Freedom Cemetery		22d. LOCATION (City, town, or county) (State) New Freedom, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns		ADDRESS Towson, Maryland	
24a. REC'D BY REGISTRAR Sept. 24, 1957		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

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SEP 04 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9247 CERTIFICATE OF DEATH

Reg. Dist. No. 09245

1. PLACE OF DEATH a. COUNTY <u>Bolto</u> Md MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER 54 20</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11 Hawthorn Rd</u>				d. STREET ADDRESS <u>11 Hawthorn Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Margaret E McGrath</u>				4. DATE OF DEATH Month <u>9</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH <u>1-17-1869</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>Md</u>			
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>LAWRENCE McGroth</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Biggin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Marie Hughes</u>		Address <u>JAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic cardio-vascular disease</u> DUE TO <u>disease</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan 15, 1953</u> , to <u>Sept 21, 1957</u> , that I last saw the deceased alive on <u>Sept 20, 1957</u> , and that death occurred at <u>5:10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph Miceli</u>				ADDRESS (Street, city or town, state) <u>108 S Taylor Ave</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI</u>				DATE SIGNED <u>9/23/57</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF <u>9-23-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cath Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Brydinski</u>				ADDRESS <u>1407 Eastern Ave</u>		24a. REC'D BY REGISTRAR <u>SEP 25 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>			

9248

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VAH FORT HOWARD, MD.				c. LENGTH OF STAY IN TB 10 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
				d. STREET ADDRESS 1114 N. Kenwood Ave.			
3. NAME OF DECEASED (Type or print) Frank J. McKenna				4. DATE OF DEATH September 14 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 8, 1920	
				9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning			
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frank McKenna				14. MOTHER'S MAIDEN NAME Eleanor Kelly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW II				16. SOCIAL SECURITY NO. 215-14-6646			
				17. INFORMANT Address Clin Rec. Vet Adm Hosp., Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF THE LIVER FAR ADVANCED 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BLEEDING ESOPHAGEAL VARICIES SECONDARY TO #1 DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH unknown unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from September 4, 1957 , to Sept. 14 , 19 57 . and that death occurred at 5:42 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED HAROLD R. JOHNSON M.D. 9/15/57							
ACTUAL SIGNATURE HAROLD R. JOHNSON M.D.							
PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON, M. D. VAH, Fort Howard, Md. 9/15/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) 5501 Frederick Ave, Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Em.-Cook-Blight Funeral Home, 6009 Harford Rd. Balto., Md.				24a. REC'D BY REGISTRAR SEP 17 1957			
				24b. REGISTRAR'S SIGNATURE Lawson L. Farley			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Form No. 10

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES J. JENNINGS		M		30		JAN 15 1927	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
NEW YORK		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE AT DEATH	
SEP 18 1957		NEW YORK		10:00 AM		98.6	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF ENTRY		PLACE OF ENTRY	
[Signature]		[Signature]		SEP 18 1957		NEW YORK	

BUREAU V. S.

SEP 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9249

CERTIFICATE OF DEATH

09247

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 Vol-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in The Pines 16 Rusting Ave		d. STREET ADDRESS 618 N.Hilton St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna M. Mehrling First Middle Last		4. DATE OF DEATH Sept. 28, 19 57 Month Day Year	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1878
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady Kuhfuss Bakery		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Mehrling		14. MOTHER'S MAIDEN NAME Mary Adams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Address Mrs William Foxworth, 618 N.Hilton St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial insufficiency 422.1 DUE TO Arteriosclerotic cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 6, 19 54 to Sept. 28, 19 57 , that I last saw the deceased alive on September 28, 19 57 , and that death occurred at 5:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4116 Edmondson Avenue DATE SIGNED 9/30/57			
ACTUAL SIGNATURE George A. Knipp		M.D. 4116 Edmondson Avenue	
PHYSICIAN'S NAME (Type) George A. Knipp, M. D.		Baltimore 29, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 1/57	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR OCT 2 '57 24b. REGISTRAR'S SIGNATURE Quelch	

BUREAU V. S.

OCT 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9250

CERTIFICATE OF DEATH

09248

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines				e. STREET ADDRESS 2533 Westport Ave.			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last MILLER, Sr.				4. DATE OF DEATH Month Sept. Day 27, Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 11, 1872	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mould Maker		10b. KIND OF BUSINESS OR INDUSTRY Carr-Lowrey Glass		11. BIRTHPLACE (State or foreign country) Millville, N.J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Frederick Miller				14. MOTHER'S MAIDEN NAME Elizabeth Dempsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-01-3840A		17. INFORMANT Mr. William H. Miller, Jr. Address Linthicum Hgts, Md. 516 Shipley Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute pulmonary edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Large st. irregular hemia						INTERVAL BETWEEN ONSET AND DEATH 30 minutes 1 yr +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 1956, to Sept. 27 , 1957, that I last saw the deceased alive on Sept 27 , 1957, and that death occurred at 10:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE John A. Nesbitt, Jr. M.D. 1118 St. Paul St.				PHYSICIAN'S NAME (Type) JOHN A. NESBITT, JR. Baltimore 2, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/30/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto.				24a. REC'D BY REGISTRAR DATE 9/30/57		24b. REGISTRAR'S SIGNATURE D. H. Hedrick	

BUREAU V. S.

OCT 1 1957

RECEIVED

9161

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 53	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7452 Laurence Road		d. STREET ADDRESS 7452 Laurence Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANTHONY C. MILLI Middle Last		4. DATE OF DEATH Month Sept. Day 10 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1904
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stanley Milli		14. MOTHER'S MAIDEN NAME Sophia Rudolph	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) Yes W W 11		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Alice Milli 7452 Laurence Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 15 min 5 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6 to 57 , that I last saw the deceased alive on 9-6 , and that death occurred at 340 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Jack C Collins M.D. 2 Kingship 9-12-57 PHYSICIAN'S NAME (Type) JACK C Collins Baltimore 22 Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 14, 1957	22c. NAME OF CEMETERY OR CREMATORY Belair Memo. Gardens	22d. LOCATION (City, town, or county) (State) Belair, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.		24. REGISTERED BY REGISTRAR—24b. REGISTRAR'S SIGNATURE SEP 17 1957 Mr. Kelly	

BUREAU V. 8

SEP 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09250

9251

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 23yr5mth24dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital			d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Donald Middle Johnson Last Morgan			4. DATE OF DEATH Month Sept. Day 16 Year 19 57		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17, 1892	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) travelling salesman		10b. KIND OF BUSINESS OR INDUSTRY photography		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Charles H. Morgan		
14. MOTHER'S MAIDEN NAME Laura Marshall			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		
16. SOCIAL SECURITY NO. unknown			17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x DUE TO Pending Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL VASCULAR ACCIDENT DUE TO (c) CEREBRAL & GENERALIZED ARTERIOSCLEROSIS					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Baltimore	(State) Maryland
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE George M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9-16-57	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/18/57	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight Inc.		ADDRESS 6009 Harford Rd.		24a. REC'D BY REGISTRAR DATE SEP 17 '57	24b. REGISTRAR'S SIGNATURE Wm. Leach

RECEIVED
SEP 18 1957
BUREAU V. S.

9252

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 4 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 23 Ridge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles A. H. Mueller		4. DATE OF DEATH Month Day Year Sept. 2, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 5, 1875
9. AGE (In years birth day) yrs. 82		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY Own Business	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME -----Mueller		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. M	
17. INFORMANT Mrs. Curtis F. Davis, 610 N. Chapelgate Lane.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 794X CLREMIA - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SECONDARY ANEMIA - DUE TO (c) CACLEXIA			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/29 , 19 57 , to 9/2 , 19 57 , that I last saw the deceased alive on 9/3 , 19 57 , and that death occurred at 11:45 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John H. Shaw M.D. 5800 Edmondson Ave. 9/4/57			
ACTUAL SIGNATURE John H. Shaw		PHYSICIAN'S NAME (Type) JOHN H. SHAW M.D. BALTO. 25, MD	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 5/57	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or county) (State) Baltimore 7, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR SEP 6 '57	
24b. REGISTRAR'S SIGNATURE Reese			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

Name of Deceased		John Doe	
Age		45 yrs	
Sex		Male	
Race		White	
Marital Status		Married	
Occupation		Farmer	
Usual Residence		123 Main St, Baltimore, MD	
Cause of Death		Heart Disease	
Date of Death		Sept 10, 1957	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

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1. The Registrar, Baltimore, MD, has received the following information from the physician who attended the deceased:

2. The deceased was born on [Date] at [Place] and was [Age] years of age at the time of death.

3. The deceased was [Married/Single] and was [Occupation] by profession.

4. The deceased was [Usual Residence] at the time of death.

5. The deceased died on [Date] at [Place] of [Cause of Death].

6. The deceased was [Signature] by the physician who attended the deceased.

7. The deceased was [Signature] by the Registrar.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09252

9253

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence, before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville Owings Mills</u>				c. LENGTH OF STAY IN 1b <u>7 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caves Road</u>				d. STREET ADDRESS <u>1 Caves Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Alexander Munn Jr</u>				4. DATE OF DEATH Month Day Year <u>Sept 5 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 25, 1913</u>	9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>American Int'l. Bldg. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Alexander Munn</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Paul</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>261-40-57152</u>		17. INFORMANT Address <u>Mrs C.A. Munn Jr Caves Rd, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>amyotrophic lateral sclerosis</u> 356.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u> DUE TO (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>5 Sep</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>30 Aug</u> , 19 <u>57</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul H Royse</u>		M.D. <u>808 Reisterstown Rd</u>		DATE SIGNED <u>5 Sep 57</u>			
PHYSICIAN'S NAME (Type) <u>Paul H Royse</u>		<u>Pikesville 8 - Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) (State) <u># Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Meeks</u> ADDRESS <u>Box 805 N. Calvert St</u>				24a. REC'D BY REGISTRAR <u>SEP 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Cline</u>	

RECEIVED

9254

CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Raspburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Raspburg x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 412 Walcott Road		d. STREET ADDRESS 412 Walcott Road	
3. NAME OF DECEASED (Type or print) First HENRY Middle NIES Last		4. DATE OF DEATH Month Sept. Day 17 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 23, 1897
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Nies		14. MOTHER'S MAIDEN NAME Kate Heiger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. No.	
17. INFORMANT Mrs. Rachel Nies 412 Walcott Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage 443x DUE TO (b) Hypertensive cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 week			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 19 57 to Sept. 19 57 , that I last saw the deceased alive on Sept. 16, 19 57 , and that death occurred at 6:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6801 Belair Rd Baltimore, Md. DATE SIGNED Sept 17 57 ACTUAL SIGNATURE Charles M. Kerr MD PHYSICIAN'S NAME (Type) Charles M. Kerr MD Baltimore, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 20, 1957	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn	22d. LOCATION (City, town, or county) (State) Colgate, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.		24. REGISTRAR'S SIGNATURE A. J. P. Schneider	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. No. 10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9255

CERTIFICATE OF DEATH

Reg. Dist. No.

09254

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Gilead Road		d. STREET ADDRESS 1 Mt. Gilead Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jennie Middle Rozella Last Osborn		4. DATE OF DEATH Month Sept. Day 24 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1899
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George F. Wagner		14. MOTHER'S MAIDEN NAME Rebecca Ann Leppo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Wm. Edgar Osborn, Reisterstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Hypertensive C-V Disease DUE TO (c) 8 yrs. INTERVAL BETWEEN ONSET AND DEATH 21 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m. none		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) none	
(County)		(State)	
21. I certify that I attended the deceased from 12-1-36 , 19____, to 9-24-57 , 19____, that I last saw the deceased alive on 9-23-57 , 19____, and that death occurred at 8:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 9-27-57			
ACTUAL SIGNATURE D. D. Caples		M.D. 6 Hanover Rd.	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 27/57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Gilead		22d. LOCATION (City, town, or county) (State) Reisterstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons, Reisterstown, Md.		ADDRESS Reisterstown, Md.	
24a. REC'D BY REGISTRAR 9-27-57		24b. REGISTRAR'S SIGNATURE Nancy B. Eline	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

2800

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>Jan 1, 1900</i></p>		<p>4. Place of birth: <i>New York, N.Y.</i></p>	
<p>5. Date of death: <i>Dec 15, 1957</i></p>		<p>6. Place of death: <i>Home</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Manner of death: <i>Natural</i></p>	
<p>9. Signature of physician: <i>Dr. J. Smith</i></p>		<p>10. Signature of registrar: <i>John Doe</i></p>	

BUREAU V. S.

12 30 1957

RECEIVED

9256

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 50 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 734 Charing Cross		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Crockett Last Paradee		4. DATE OF DEATH Month Sept. Day 25 Year 19 57	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1892
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk In Charge U.S. Postal Trans.		10b. KIND OF BUSINESS OR INDUSTRY Pocomoke City	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <input type="checkbox"/>	
17. INFORMANT Mrs Anna Paradee, 734 Charing Cross		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate case (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA - STOMACH INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-12 , 19 57 , to 9-25 , 19 57 , that I last saw the deceased alive on 9/25/57 , 19 57 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1103 ST. PAUL ST. DATE SIGNED 9-26-57			
ACTUAL SIGNATURE Hugh M. Brown		PHYSICIAN'S NAME (Type) Witzke Funeral Directors, 4101 Edmondson Ave.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sep. 28/57	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR SEP 28 57	
24b. REGISTRAR'S SIGNATURE W. J. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		35		Jan 1, 1922	
Place of Birth		Cause of Death		Date of Death		Time of Death	
Baltimore, Md.		Heart Disease		Jan 15, 1957		10:30 AM	
Occupation		Manner of Death		Physician's Signature		Hospital or Place of Death	
Teacher		Natural		J. A. Smith, M.D.		St. Mary's Hospital	
Signature of Informant		Informant's Name		Informant's Address		Informant's Phone	
J. A. Smith		John Doe		123 Main St.		123-4567	
Signature of Registrar		Registrar's Name		Registrar's Address		Registrar's Phone	
J. B. Jones		John Doe		123 Main St.		123-4567	

BUREAU V. 8

SEP 30 1957

RECEIVED

9257

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Overlea</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Overlea</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>307 Willow Avenue</i>		d. STREET ADDRESS <i>1 307 Willow Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Mr. Walter Franklin Preston</i> (also known as <i>Frank M. Preston</i>)		4. DATE OF DEATH Month <i>September</i> Day <i>14</i> Year <i>1957</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 10, 1885</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Government</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Edgewood Arsenal</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>
13. FATHER'S NAME <i>John Preston</i>		14. MOTHER'S MAIDEN NAME <i>Sarah</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>215-16-9936</i>	
		17. INFORMANT Address <i>Mrs. Sophia C. Preston, 307 Willow Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Acute cardiovascular collapse</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary thrombosis with infarction 4 mpr.</i> DUE TO (c) <i>Coronary heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic emphysema and bronchial asthma</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>— 19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>7:22</i> 19 <i>54</i> , to <i>Sept</i> 19 <i>57</i> , that I last saw the deceased alive on <i>Sept 4</i> 19 <i>57</i> , and that death occurred at <i>12:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles M. Kerr</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>6801 Belair Road #6</i> <i>Sept 16, 57</i>	
PHYSICIAN'S NAME (Type) <i>Dr. Charles M. Kerr.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/17/1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Harford Co. Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>SEP 19 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Mrs. L. L. Reysenbery</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED _____ SEX _____ AGE _____ DATE OF BIRTH _____ PLACE OF BIRTH _____ OCCUPATION _____ MARITAL STATUS _____ EDUCATION _____ RELIGION _____ RACE _____ COLOR _____ HEIGHT _____ WEIGHT _____ BUILD _____ HAIR _____ EYES _____ SKIN _____ TENDRILS _____ SCARS _____ TATTOOS _____ OTHER _____ SIGNATURE OF DECEASED _____ DATE OF SIGNATURE _____		PLACE OF DEATH _____ DATE OF DEATH _____ TIME OF DEATH _____ CAUSE OF DEATH _____ MANNER OF DEATH _____ MEDICAL HISTORY _____ PRESENT ILLNESS _____ TREATMENT _____ PHYSICIAN _____ NURSE _____ HOSPITAL _____ CITY _____ STATE _____ ZIP CODE _____
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RECEIVED
 SEP 19 1957
 BUREAU V. 1

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09257

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write name and give nearest town) <u>Kingsville</u>	c. LENGTH OF STAY IN 1b <u>life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 2 Kingsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Belair Rd at New Cut Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BERTHA MAY PRICE</u>	4. DATE OF DEATH <u>Sept. 28</u>	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 13, 1891</u>
9. AGE (In years last birthday) <u>66</u> yrs.	10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Victor Bond</u>		14. MOTHER'S MAIDEN NAME <u>May Temple</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Husband</u>		Address <u>Grove Address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Cidam's Stokes Syndrome</u> Conditions, if any, which gave rise to immediate cause (b) <u>Myocardial Enlargement</u> (c) <u>Hypertension</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank T. Kasik Jr.</u>		DATE SIGNED <u>Sept 28, 1957</u>	
EXAMINER'S NAME (Type) <u>FRANK T. KASIK JR.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 2, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>	22d. LOCATION (City, town, or county) (State) <u>Kingsville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		24. REGISTRAR'S SIGNATURE <u>Dr. Walter Hammett</u>	

FOR STATE
HEALTH DEPT.

MARYLAND DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
OCT 1 1957
BUREAU V. S.

9259

CERTIFICATE OF DEATH

092583 ✓

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Wilson Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs 15562</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt Wilson State Hospital</u>				d. STREET ADDRESS <u>1219 Remington Dr</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alberta Bolton Reed</u>				4. DATE OF DEATH Month Day Year <u>Sept 21 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-12-1909</u>	
9. AGE (In years last birthday) yrs. <u>48</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>48</u>		IF UNDER 24 HRS. <u>48</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Punch Press Oper.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Motors</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>							
13. FATHER'S NAME <u>Clarence Bolton</u>				14. MOTHER'S MAIDEN NAME <u>Louise Nevins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>153-18-9909</u>		17. INFORMANT Address <u>Hospital Records Mt Wilson State Hosp</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis, Far adv.</u> DUE TO <u>002X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atelectasis and Pneumonia Left</u> DUE TO <u>9-20-57</u> (c) <u>Pneumectomy - Rt.</u> DUE TO <u>9-10-57</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Segmental Resection Left Lung</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1-16-57</u> , 19 <u>57</u> , to <u>9-21-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-21-57</u> , 19 <u>57</u> , and that death occurred at <u>8 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Newcomer</u> M.D.				ADDRESS (Street, city or town, state) <u>Mt Wilson Md</u> DATE SIGNED <u>9-21-57</u>			
PHYSICIAN'S NAME (Type) <u>William Newcomer</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Colonial Memo Park</u>		22d. LOCATION (City, town, or county) (State) <u>Trenton N.J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Hartman, Trenton, N.J.</u>				ADDRESS <u>Per Frank W. Newell, Baltimore, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 25 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Anthony Threlk</u>							

SEP 25 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9260

CERTIFICATE OF DEATH

09259

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>				c. LENGTH OF STAY IN TB <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Belair Road, Glen Arm P.O.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>G.</u> Last <u>Reichert</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/14/1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>80</u> Days <u>80</u> Hours <u>80</u> Min. <u>80</u>		IF UNDER 24 HRS. Months <u>80</u> Days <u>80</u> Hours <u>80</u> Min. <u>80</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Philipp Reichert</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Elizabeth Schroeder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs. Catherine Reichert Belair Rd. Glen Arm PO</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute bronchopneumonia</u> <u>480x</u> DUE TO <u>La Grippe</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>10 days</u> (c) <u>24 hrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9-17</u> , 19 <u>57</u> , to <u>9-20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-19</u> , 19 <u>57</u> , and that death occurred at <u>1 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clifford F. Hudson</u> M.D.				ADDRESS (Street, city or town, state) <u>FORK, MD.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Perry Hall Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Lorraine Funeral Home 2401 Belair Road</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 27 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Dr. Walter H. Harty</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
CERTIFICATE OF DEATH

RECEIVED

SEP 27 1957

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09260

Reg. Dist. No.

9261

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Caton Ridge Manor Nursing Home, Harlee Lane</u>				d. STREET ADDRESS <u>Armisted Gardens 3401-4 1106 Quantril Way</u>			
3. NAME OF DECEASED (Type or print) First <u>Maude M.</u> Middle <u>Rhinebolt</u> Last				4. DATE OF DEATH Month <u>Sept.</u> Day <u>13</u> Year <u>1957</u> 19			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mch. 10. 1892</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>05</u> Days <u>05</u> Hours <u>00</u> Min.		IF UNDER 24 HRS. Months <u>00</u> Days <u>00</u> Hours <u>00</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Penna</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>William Zimmerman</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Charles E. Rhinebolt</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac failure</u> DUE TO (b) <u>Cardiovascular disease Hypertensive</u> (c) <u>Diabetes Mellitus</u> DUE TO (d) <u>Fracture left femur Accident</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture corrected by operation at St. Agnes Hospital</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Fracture and Fell down steps (stone) at home causing injury lacerations</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>May 9, 1957</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Baltimore Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>Sept. 15, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Leichty Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Somerset Co. Pa.</u>				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc.</u>				ADDRESS <u>1217 St. Paul St.</u>		24a. REC'D BY REGISTRAR <u>SEP 17 '57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Reed Smith</u>		DATE	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 17 1957

RECEIVED

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Baltimore County MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MD. b. COUNTY BALTIMORE					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. LENGTH OF STAY IN 1b RURAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital						d. STREET ADDRESS Rt. 144 2802 Frederick Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL WILLIAM RIDGLEY						4. DATE OF DEATH Month Day Year 9 21 1957					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-21-1883		9. AGE (In years last birthday) yrs. 73		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) SYKESVILLE, MD.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL G. RIDGLEY						14. MOTHER'S MAIDEN NAME MARY ANN HUGHES					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-05-2965		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis DUE TO Pleural effusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 months											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9-19-1957 , to 9-21-1957 , that I last saw the deceased alive on 9-21-57 , and that death occurred at 3:42 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED _____ ACTUAL SIGNATURE William Newcomer M.D. PHYSICIAN'S NAME (Type) William Newcomer, M. D., Superintendent											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9-24-57		22c. NAME OF CEMETERY OR CREMATORY Highland View		22d. LOCATION (City, town, or county) (State) Barrett, Md			
23. FUNERAL DIRECTOR'S SIGNATURE J. C. Hays						ADDRESS Ellicott City, Md		24a. REC'D BY REGISTRAR SEP 23 1957		24b. REGISTRAR'S SIGNATURE Dorothy Jewell	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 8

SEP 23 1957

RECEIVED

9263

CERTIFICATE OF DEATH

Reg. Dist. No.

09262

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home		d. STREET ADDRESS 708 Winan's Way	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle A. Last ROBINSON		4. DATE OF DEATH Month Sept. Day 1, Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1882
9. AGE (In years last birthday) yrs. 74		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Penna.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Frederick Schlimme		14. MOTHER'S MAIDEN NAME --	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO. --	
17. INFORMANT Mr. Harry L. Robinson - 708 Winan's Way		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Carcinomatosis 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Rt. Breast DUE TO (c) 1 1/2 yr.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 1956 to Sept. 1 , 1957, that I last saw the deceased alive on Sept. 1 , 1957, and that death occurred at 5:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9/3/57 DATE SIGNED ACTUAL SIGNATURE A. P. Von Schuch M.D. 4818 Edmondson Ave PHYSICIAN'S NAME (Type) A. P. Von Schuch M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/4/57	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Vickner & Son - Balto. 17th		24a. REC'D BY REGISTRAR SEP 6 '57	
24b. REGISTRAR'S SIGNATURE W. J. Vickner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WESTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 11
CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to the quality of the scan.

RECEIVED
SEP 9 1957
BUREAU V. S.

9264

CERTIFICATE OF DEATH

Reg. Dist. No.

0926331

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) xo Randallstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Edgewood Rd.		d. STREET ADDRESS Edgewood Rd.	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle M. Last RODDY		4. DATE OF DEATH Month 9 Day 11 Year 1955	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY self	9. AGE (In years last birthday) 79 yrs.
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? Months Days Hours Min.	
13. FATHER'S NAME Simon Roddy		14. MOTHER'S MAIDEN NAME Susan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. C. Gardner Disney - Edgewood Rd.		Address Randallstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 4 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/10 , 19 55 , to 9/11 , 19 55 , that I last saw the deceased alive on 9/10 , 19 55 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8204 LIBERTY RD, BALTO, MD DATE SIGNED 9/11/55			
ACTUAL SIGNATURE Edwin L. Pierpont		M.D. 8204 LIBERTY RD, BALTO, MD	
PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/14/55	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	22d. LOCATION (City, town, or county) (State) Woodlawn, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edwin L. Pierpont		24a. REC'D BY REGISTRAR SEP 16 1955	24b. REGISTRAR'S SIGNATURE Dr. J. Martin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1007 70

RECEIVED
 SEP 16 1957
 BUREAU V. 2

9265

CERTIFICATE OF DEATH

09264
Reg. Dist. No.

39

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix				c. LENGTH OF STAY IN TB life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Phoenix Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edward Price Royston				4. DATE OF DEATH Month Day Year 9-16-57 19			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-1873	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmaster		10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marion Royston				14. MOTHER'S MAIDEN NAME Susanna Price			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address E. F. Royston, Phoenix, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE , 1957, to Sept 16th , 1957, that I last saw the deceased alive on Sept. 13th , 1957, and that death occurred at 4:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED M. X. Quinn M.D. 1927 York Rd, TIMONIUM, Md. 9/16/57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) MICHAEL KEVIN QUINN M.D. 1927 YORK RD., TIMONIUM, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-18-57		22c. NAME OF CEMETERY OR CREMATORY St. James Episcopal		22d. LOCATION (City, town, or county) (State) Monkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks ADDRESS 622 York Rd. Towson # 4, Md.				24a. REC'D BY REGISTRAR SEP 18 1957		24b. REGISTRAR'S SIGNATURE Elly Grunich	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
SEP 18 1957
BUREAU V. A.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 189265

9266

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Swings Mills (R)</u>		c. LENGTH OF STAY IN 1b <u>3 year</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer Park Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martin</u> Middle <u>A.</u> Last <u>Ruffert</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27, 1895</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life) even if retired <u>Planning Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Inspector</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William Ruffert</u>		14. MOTHER'S MAIDEN NAME <u>Magdalena Grossman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Edith Liffurcott</u>		Address <u>Randalltown</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Myocarditis</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>36 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 19, 1957</u> , to <u>Sept. 19, 1957</u> , that I last saw the deceased alive on <u>Sept. 19, 1957</u> , and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. E. Martin</u>		M.D. <u>Randalltown Md</u> DATE SIGNED <u>9/21/57</u>	
PHYSICIAN'S NAME (Type) <u>Wm. E. MARTIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/23/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Graves Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Liberty Road Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE <u>9/21/57</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Wm. E. Martin</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 04 1957

RECEIVED

9267

CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER XO</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2005 OAKLAND AVE.</u>				d. STREET ADDRESS <u>2005 OAKLAND AVE.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>THELMA C RUPPRECHT</u>				4. DATE OF DEATH Month Day Year <u>SEPT. 13 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/2/1914</u>	
9. AGE (In years last birthday) yrs. <u>43</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PENN</u>			
11. BIRTHPLACE (State or foreign country) <u>PENN</u>				12. CITIZEN OF WHAT COUNTRY? <u>✓</u>			
13. FATHER'S NAME <u>ISAAC CONRAD</u>				14. MOTHER'S MAIDEN NAME <u>DRA COUNTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>0</u>				16. SOCIAL SECURITY NO. <u>213-34-4768</u>			
17. INFORMANT <u>WM. RUPPRECHT</u>				Address <u>SAME AS ABOVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma larynx & trachea</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Carcinoma stomach</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS</u> <u>3 Mo</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>57</u> to <u>SEPT 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>SEPT 13</u> , 19 <u>57</u> , and that death occurred at <u>11:30 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2108 ORMS B.</u> DATE SIGNED <u>9/16/57</u> ACTUAL SIGNATURE <u>Louis Semenov</u> M.D. <u>2108 ORMS B.</u> PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOV</u> <u>BALTIMORE 20, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 17-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ZION LUTHERAN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u>				ADDRESS <u>Box 21 2nd SEP 18 1957</u>			
24a. REC'D BY REGISTRAR <u>Edith Hurley</u>				24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>			

CERTIFICATE OF DEATH

RECEIVED
BUREAU V. R.
 SEP 18 1957

NAME OF DECEASED [Faint handwritten name]	
SEX [Faint handwritten sex]	AGE [Faint handwritten age]
DATE OF DEATH [Faint handwritten date]	
PLACE OF DEATH [Faint handwritten place]	
CAUSE OF DEATH [Faint handwritten cause]	
MANNER OF DEATH [Faint handwritten manner]	
SIGNATURE OF DECEASED [Faint handwritten signature]	
SIGNATURE OF WITNESS [Faint handwritten signature]	
SIGNATURE OF PHYSICIAN [Faint handwritten signature]	
SIGNATURE OF CLERK [Faint handwritten signature]	

CERTIFICATE OF DEATH

Reg. Dist. No.

09267

9170

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ENGLISH CONSUL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ENGLISH CONSUL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2805 LOUISIANA AVE		d. STREET ADDRESS 2805 LOUISIANA AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE HENRY SCHAEFER		4. DATE OF DEATH SEPT 14 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC-2-1875
9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCKER		10b. KIND OF BUSINESS OR INDUSTRY B&O. R.R.	11. BIRTHPLACE (State or foreign country) BALTIMORE MD
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME HEINRICH G. SCHAEFER		14. MOTHER'S MAIDEN NAME LENA ALBRIGHT ALBERT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705-05-8450	
17. INFORMANT EMMA E. MC. KELDIN		Address 2805 Louisiana Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA - HEAD OF PANCREAS 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH ABOUT 1 YR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARDIO-VASCULAR DISEASE - ARTERIOSCLEROSIS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 OCT 1957 to 14 SEPT 1957 , that I last saw the deceased alive on 6 SEPT 1957 , and that death occurred at 10:10 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward F. Milan		DATE SIGNED 9/15/57	
PHYSICIAN'S NAME (Type) EDWARD F. MILAN MD		ADDRESS (Street, city or town, state) 682 WASHINGTON (B&O) BALTIMORE 30 MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 17 1957	
22c. NAME OF CEMETERY OR CREMATORY Louison Park		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE John P. Deifel		ADDRESS 5311 Edmondson St	
24a. REC'D BY REGISTRAR DATE 16 1957		24b. REGISTRAR'S SIGNATURE Dr Geo M. Ruffey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint, illegible markings.

BUREAU V. S.

SEP 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9268

CERTIFICATE OF DEATH

09268

Items 11 & 12, Film G220, 9/26/57

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevenson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevenson</u> x o	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Villa Julie</u>		d. STREET ADDRESS <u>Valley Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sister Mary Rosina (Schneiderhan)</u>		4. DATE OF DEATH Month Day Year <u>Sept. 21 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 26, 1895</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u>	11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN SCHNEIDERHAN</u>	
14. MOTHER'S MAIDEN NAME <u>ANNA KRAFT</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>--</u>	
16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT Address <u>Villa Julie Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer Lungs</u> 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer Breast.</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>5-6 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan 1957</u> , to <u>Sept 21, 1957</u> , that I last saw the deceased alive on <u>Sept 20</u> , 1957, and that death occurred at <u>2 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Harold H Burns</u> M.D. <u>115 E. Eager St</u> <u>9-23-57</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>Harold H. Burns</u> <u>Baltimore Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-23-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Convent</u>	22d. LOCATION (City, town, or county) (State) <u>Ilchester Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home Catonsville Md,</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 24 '57</u>	
24b. REGISTRAR'S SIGNATURE <u>Quelch</u>			

BUREAU V. S.

SEP 24 1957

RECEIVED

0926938

9269

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. LENGTH OF STAY IN 1b <u>xo</u> <u>Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3015 Woodside Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Louis F.</u> Middle <u>Schruter</u> Last <u></u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 1, 1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bedding</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Schruter</u>			
14. MOTHER'S MAIDEN NAME <u>Teresa</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>213031328</u>				17. INFORMANT Address <u>Mrs. Myrtle Cimino 3015 Woodside Ave. #14</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks 4 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9/24</u> , 19 <u>57</u> , to <u>9/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>was D.O.A.</u> , 19 <u>57</u> , and that death occurred at <u>4:30</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George H. Beck</u> M.D.				ADDRESS (Street, city or town, state) <u>Charles & 34th St Baltimore, Md.</u>			
DATE SIGNED <u>9/22/57</u>							
PHYSICIAN'S NAME (Type) <u>GEORGE H. BECK</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, Inc.</u>				ADDRESS <u>5305 Harford Rd.</u>			
24a. REC'D BY REGISTRAR <u>SEP 25 1957</u>				24b. REGISTRAR'S SIGNATURE <u>L. H. M. Bacon</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

SEP 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09270

Reg. Dist. No.

42

Items 3,7 FilmG221 10-4-57 et.

1. PLACE OF DEATH a. COUNTY <u>Edith Elizabeth Schulz</u> <u>Baltimore</u> <u>MD</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oaklee Arbutus</u>		c. LENGTH OF STAY IN 1b <u>29</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>919 Leeds Ave Oaklee</u>		d. STREET ADDRESS <u>919 Leeds Ave Oaklee</u>	
3. NAME OF DECEASED (Type or print) <u>Edith Elizabeth</u> <u>Schulz</u>		4. DATE OF DEATH Month <u>Sep.</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 5. 1967</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>usa</u>	
13. FATHER'S NAME <u>William Kisting</u>		14. MOTHER'S MAIDEN NAME <u>Mary Shade</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Myrtle F Jones</u>		Address <u>919 Leeds Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>9030</u> <u>Acute Cardiac Failure</u> DUE TO <u>Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u>Accident Fracture right femur or hip</u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Jan. 11 57 fell on the floor causing a fracture of her leg.</u> <u>Jan 22 1957 Head over on floor fracture corrected (Univ. Hosp.)</u> 20a. EXTERNAL CAUSE WAS IT A FALL? <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (State of injury in Part I or Part II of item 18.) PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <u>Fell on the floor causing fracture of femur Right.</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>9:30 PM Jan. 11, 57</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Oaklee Arbutus Balto. Co. Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo. M. Kieffer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Geo. S.M. Kieffer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Interred Oct. 1-57</u>		22b. DATE THEREOF <u>Oct. 1-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Howard Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. L. Webb - 1300 Eustace Ave</u>		24a. REC'D BY REGISTRAR <u>OCT 2 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Dr. Geo. M. Kieffer</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

BUREAU V. S.

OCT 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9162

09271

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colgate</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colgate</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>17820 Eastern Ave</u>			
3. NAME OF DECEASED (Type or print) <u>EMMA</u> First Middle Last				4. DATE OF DEATH <u>9-27</u> 19 <u>57</u> Month Day Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-10-1878</u> yrs.	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wire</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT-Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRED Appel</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>EDWARD Schweiger (SAME)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>49</u> , to <u>Sept.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept. 24</u> , 19 <u>57</u> , and that death occurred at <u>2:00 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clarence W. LeDoux</u> M.D.				ADDRESS (Street, city or town, state) <u>3023 Eastern Ave.</u>		DATE SIGNED <u>9/30/57</u>	
PHYSICIAN'S NAME (Type) <u>Clarence W. LeDoux, M.D.</u>				Baltimore, 24, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>9-30-57</u>		<u>OAK-LAWN</u>		<u>Balto</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>10-2-57</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. M. Kelly, Jr.</u> E.T.	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9270

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		J	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>#2 Bridge, Loch Raven</u> <u>Baltimore City, Maryland</u>				d. STREET ADDRESS <u>Paca & Fayette Sts.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALLEN</u> Middle <u>BAIR</u> Last <u>Sharpe</u>				4. DATE OF DEATH Month <u>September</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/13/27</u>	9. AGE (In years last birthday) <u>30</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>		11. BIRTHPLACE (State or foreign country) <u>Minersville Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Allan Sharpe Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Lena Bertram</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>WW2</u>		16. SOCIAL SECURITY NO. <u>209-14-9615</u>		17. INFORMANT <u>Mrs. Lena Sharpe</u> Address <u>850 Water St. Pottsville</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Working as painter dropped Brush Scream after it</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 30, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Govan's Presbyterian</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Dumas</u>				24a. REC'D BY REGISTRAR <u>Dr. L. M. Bacon</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. L. M. Bacon</u>	
				DATE <u>29 1957</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

OCT 29 1957

RECEIVED

9271

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xo Rural Notch Cliff near Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road		d. STREET ADDRESS Glenarm Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sister Mary Josephine Siegrist		4. DATE OF DEATH Month Sept. Day 11 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1875
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS	11. BIRTHPLACE (State or foreign country) Sellersville, Pa.
13. FATHER'S NAME Henry		14. MOTHER'S MAIDEN NAME Johanna Klein	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Sister M. Peter Fourier Notch Cliff, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 48 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 27 , 19 55 , to Sept. , 19 57 , that I last saw the deceased alive on Sept. 10 , 19 57 , and that death occurred at 10:35 M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell		ADDRESS (Street, city or town, state) DATE SIGNED 9.11.57	
PHYSICIAN'S NAME (Type) Charles F. O'Donnell			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-13-57	22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM.	22d. LOCATION (City, town, or county) (State) NOTCH CLIFF NR TOWSON, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Seiler		24a. REC'D BY REGISTRAR SEP 16 1957	
ADDRESS 901 S. CONKLING ST. BALTO., 24, MD.		24b. REGISTRAR'S SIGNATURE Metel Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

SEP 17 1957

RECEIVED

9272

CERTIFICATE OF DEATH

09273

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 13yr7mth22dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Maryland		f. STREET ADDRESS 5301 Taylor Avenue	
3. NAME OF DECEASED (Type or print) First Aslang Middle Hiortdahl Last Silvey				4. DATE OF DEATH Month 9 Day 8 Year 19 57		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 30, 1878	9. AGE (In years last birthday) yrs. 78	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Norway	
13. FATHER'S NAME Richard Hiortdahl				14. MOTHER'S MAIDEN NAME Josephine Prince			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) benign brain disease - generalized arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 12 , 19 57 , to 9-8 , 19 57 , that I last saw the deceased alive on 9-8-57 , 19 57 , and that death occurred at 10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 9-8-57							
ACTUAL SIGNATURE J. VASCONCELOS				PHYSICIAN'S NAME (Type) J. VASCONCELOS			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9-19-57		22c. NAME OF CEMETERY OR CREMATORY Calverton, Md. Calverton		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Vasconcellos				24a. REC'D BY REGISTRAR SEP 20 57			
24b. REGISTRAR'S SIGNATURE W. E. Deuch				DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. RACE</p>	
<p>5. DATE OF BIRTH</p>		<p>6. PLACE OF BIRTH</p>	
<p>7. DATE OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF NEXT OF KIN</p>		<p>16. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>17. SIGNATURE OF FUNERAL HOME</p>		<p>18. SIGNATURE OF CEMETERY</p>	
<p>19. SIGNATURE OF CHURCH</p>		<p>20. SIGNATURE OF OTHER</p>	

BUREAU V. S.

SEP 23 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
92715 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

092744
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLGATE</u>		c. LENGTH OF STAY IN 1b <u>40 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLGATE xo</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7531 Cypress Ave.</u>				d. STREET ADDRESS <u>7531 Cypress</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>L.</u> Last <u>SIMMONS</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-29-1893</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES L. SIMMONS SR.</u>				14. MOTHER'S MAIDEN NAME <u>LAMBERT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>212185408</u>		17. INFORMANT <u>CARROLL SIMMONS (SAME)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (b) <u>A-S-C-V DISEASE</u> (c) <u> </u> DUE TO <u> </u> (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>NOT KNOWN</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M.B. Davis M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M-B. Davis M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cem</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly, Esq. - Md.</u>				24. REC'D BY REGISTRAR <u>SEP 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Anselm</u>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____ SEX _____ AGE _____ DATE OF BIRTH _____ PLACE OF BIRTH _____ OCCUPATION _____ MARITAL STATUS _____ PLACE OF DEATH _____ DATE OF DEATH _____ TIME OF DEATH _____ CAUSE OF DEATH _____ MANNER OF DEATH _____ SIGNATURE OF MEDICAL EXAMINER _____ OFFICIAL MEDICAL EXAMINER		NAME OF PHYSICIAN _____ SIGNATURE OF PHYSICIAN _____ OFFICIAL PHYSICIAN
NAME OF FUNERAL HOME _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____ NAME OF UNDERTAKER _____ SIGNATURE OF UNDERTAKER _____ OFFICIAL UNDERTAKER		NAME OF CLERGYMAN _____ SIGNATURE OF CLERGYMAN _____ OFFICIAL CLERGYMAN
NAME OF NEXT OF KIN _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____ NAME OF ATTORNEY _____ SIGNATURE OF ATTORNEY _____ OFFICIAL ATTORNEY		NAME OF MEDICAL EXAMINER _____ SIGNATURE OF MEDICAL EXAMINER _____ OFFICIAL MEDICAL EXAMINER

BUREAU V. S.

SEP 6 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9274

Item 9 WilmG220 9-20-57 et
CERTIFICATE OF DEATH

Reg. Dist. No.

092733

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. City</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood St. Training School</u>		d. STREET ADDRESS <u>4820 Wright St.</u>	
3. NAME OF DECEASED (Type or print) First <u>DONALD</u> Middle <u>RALPH</u> Last <u>SIMONDS</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-29-35</u>
9. AGE (In years lost birthday) <u>21</u> yrs.		IF UNDER 1 YEAR: Months <u>21</u> Days <u>16</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>EARL E. SIMONDS</u>		14. MOTHER'S MAIDEN NAME <u>PEARL WEAVER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>RECORD RM.</u>		Address <u>ROSEWOOD TRAINING SCHOOL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BILATERAL LOBAR PNEUMONIA</u> 490 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASPIRATION DURING EPILEPTIC SEIZURE</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GRAND MAL & PETIT MAL EPILEPSY, MENTAL DEFICIENCY</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-5</u> , 19 <u>57</u> , to <u>9-15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>SEPT. 16</u> , 19 <u>57</u> , and that death occurred at <u>8:35 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>ROSEWOOD ST. TRAINING SCHOOL</u> DATE SIGNED _____			
ACTUAL SIGNATURE <u>Harry G. Butler</u>		M.D. <u>OWINGS MILLS, MARYLAND</u>	
PHYSICIAN'S NAME (Type) <u>HARRY G. BUTLER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/20/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WOLF CREEK</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Brooks Bradley Jr.</u>		24a. REC'D BY REGISTRAR <u>SEP 18 1957</u>	
ADDRESS <u>Dundalk, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Elmer</u>	

BUREAU V. S.

SEP 18 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 0927639

9275

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>York Rd</u>		d. STREET ADDRESS <u>1 York Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>Rives</u> Last <u>Slaughter</u>		4. DATE OF DEATH Month <u>September</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>31 January 1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR: Months <u>2</u> Days <u>2</u> Hours <u>19</u> Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <u>Elisca, Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Ridley Rives</u>		14. MOTHER'S MAIDEN NAME <u>Estelle Agee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT Address <u>Son Frank Slaughter Sparks Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>31 August</u> , 19 <u>57</u> , to <u>2 Sept</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>31 August</u> , 19 <u>57</u> , and that death occurred at <u>6 A</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter T. Kees</u>		ADDRESS (Street, city or town, state) <u>Cockeysville Md</u> DATE SIGNED <u>2 Sept 1957</u>	
PHYSICIAN'S NAME (Type) <u>Walter T. Kees</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-5-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Monroeville</u>	22d. LOCATION (City, town, or county) (State) <u>Monroeville, Alabama</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Scott Brooks</u> ADDRESS <u>622 York Rd., Towson Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 4 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Ely Branch</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A.

SEP 4 1957

RECEIVED

9276

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u> c. LENGTH OF STAY IN 1b <u>10 yr</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2810 Emerald Rd.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u> d. STREET ADDRESS <u>2810 Emerald Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Payne</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Am</u>	6. COLOR OR RACE <u>OW</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 24 1867</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto Salesbook</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Smith</u>		14. MOTHER'S MAIDEN NAME <u>Julia Payne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-12-9834A</u>	
17. INFORMANT <u>(Daughter)</u> Address <u>ETHEL ZERRHAUT</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Adam's Stokes Syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> (c) <u>Age</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>2+ yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. j. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work No <input type="checkbox"/> while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 5</u> , 19 <u>57</u> , to <u>Sept 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 5</u> , 19 <u>57</u> , and that death occurred at <u>9:00</u> A. M., from the cause, and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Frank T. Kasik</u> M.D. <u>9005 Harford Rd</u>		<u>9/19/57</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK JR.</u>		<u>BALTO 14 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-21-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Western Mem</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Ind</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald J. Ruck</u> ADDRESS <u>5305 Harford</u>		24a. REC'D BY REGISTRAR <u>SEP 23 1957</u> 24b. REGISTRAR'S SIGNATURE <u>W M Bacon</u>	

BUREAU V. S.

SEP 23 1957

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9277

CERTIFICATE OF DEATH

09278

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>1952 W. Mulberry Street</u>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>(NONE)</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Annulled <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/3/93</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ROXBORO, N.C.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Anthony Smith</u>				14. MOTHER'S MAIDEN NAME <u>Martha Spruell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>218-01-7226</u>		17. INFORMANT <u>Clin. Rec. Folder, Vet. Adm. Hospital, Ft. Howard, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERALIZED ARTERIOSCLEROSIS; DIABETES MELLITUS</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>August 30, 1957</u> , to <u>Sept. 13, 1957</u> , and that death occurred at <u>2:00 a.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VAH, Fort Howard, Md.</u> DATE SIGNED <u>9/14/57</u> ACTUAL SIGNATURE <u>Edward A. Foster</u> M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>							
22b. DATE THEREOF <u>9/18/57</u>							
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery Baltimore, Maryland</u>							
22d. LOCATION (City, town, or county) (State)							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S. Phillips, 1808 N. Monroe St. Balto. Md.</u>							
24a. REC'D BY REGISTRAR <u>9/17/57</u>							
24b. REGISTRAR'S SIGNATURE <u>Lawson L. Farley</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		65		M		W		SEP 15 1957		BALTIMORE, MD.	
MARRIAGE		DATE OF BIRTH		DATE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
MARRIED		JAN 15 1892		SEP 15 1957		HEART DISEASE		NATURAL		J. H. HARRIS	
PREVIOUS MARRIAGES		PLACE OF BIRTH		OCCUPATION		EDUCATION		RELIGION		SIGNATURE OF FUNERAL HOME	
NONE		BALTIMORE, MD.		LABORER		HIGH SCHOOL		METHODIST		J. H. HARRIS	
PREVIOUS OCCUPATIONS		PREVIOUS RESIDENCES		PREVIOUS DEATHS		PREVIOUS INMATE		PREVIOUS MENTAL		PREVIOUS PHYSICAL	
NONE		NONE		NONE		NONE		NONE		NONE	
PREVIOUS DEATHS		PREVIOUS INMATE		PREVIOUS MENTAL		PREVIOUS PHYSICAL		PREVIOUS DRUGS		PREVIOUS ALCOHOL	
NONE		NONE		NONE		NONE		NONE		NONE	
PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS INMATE		PREVIOUS MENTAL		PREVIOUS PHYSICAL		PREVIOUS DEATHS	
NONE		NONE		NONE		NONE		NONE		NONE	

ORIGINAL INQUIRY

RECEIVED
 SEP 18 1957
 BUREAU V. S.

9/18/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																			
Item 18 Film 221-10-18-57 ans																			
9278																			
CERTIFICATE OF DEATH																			
Reg. Dist. No. 09279 44																			
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard					c. LENGTH OF STAY IN 1b 49 days														
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First JOHN Middle SOUDER Last					4. DATE OF DEATH Month September Day 26 Year 1957														
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 24, 1896		9. AGE (In years last birthday) 61 yrs.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Groom		10b. KIND OF BUSINESS OR INDUSTRY Race Track		11. BIRTHPLACE (State or foreign country) Pitman, New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A		IF UNDER 1 YEAR Months Days Hours Min.											
13. FATHER'S NAME John H. Souder					14. MOTHER'S MAIDEN NAME Hattie Turner														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I					16. SOCIAL SECURITY NO. 321-07-6687					17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Maryland									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PRIMARY TO BE DETERMINED/ Primary site Kidneys DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month VA Day 19 Hour a. m. p. m.					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)																			
21. I certify that I attended the deceased from August 8, 1957, to September 26, 1957 , and that death occurred at 10:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Veterans Administration Hospital 9/26/57																			
ACTUAL SIGNATURE Chien Wei Lan M.D. Veterans Administration Hospital 9/26/57																			
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M. D. Fort Howard, Md.																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 9/27/57					22c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery									
22d. LOCATION (City, town, or county) (State) 1300 Moreland Ave. Balto. Md.																			
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Jr. ADDRESS 6009 Harford Rd Balto. Md.										24. REC'D BY REGISTRAR SEP 27 1957					24b. REGISTRAR'S SIGNATURE Lawson L. Sharkey				

CERTIFICATE OF DEATH

STATE OF MARYLAND - DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1957

BUREAU V. 3

SEP 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9163

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dundalk-Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Dundalk</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3119 Dunglow Road</u>		d. STREET ADDRESS <u>3119 Dunglow Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANTONIA SPORNY</u>		4. DATE OF DEATH Month Day Year <u>Sept. 10, 1957</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29, 1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Gowski</u>		14. MOTHER'S MAIDEN NAME <u>Telepilja ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Agnes Frado 3119 Dunglow Road.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage.</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis.</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 Mos.</u> <u>20 years</u> <u>20 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 10</u> , 19 <u>57</u> , to <u>Sept 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 4</u> , 19 <u>57</u> , and that death occurred at <u>1 A.</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>33 Dundalk Ave Dundalk Md. 9/10/57</u>	
ACTUAL SIGNATURE <u>David H. Andrew</u> M.D.			
PHYSICIAN'S NAME (Type) <u>David H. Andrew M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 13, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dundalk, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 2112 Dundalk Ave.,</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 13 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Page 1 of 1

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. RACE [Faint text]		5. DATE OF BIRTH [Faint text]		6. PLACE OF BIRTH [Faint text]		7. DATE OF DEATH [Faint text]		8. PLACE OF DEATH [Faint text]		9. TIME OF DEATH [Faint text]		10. CAUSE OF DEATH [Faint text]		11. MANNER OF DEATH [Faint text]		12. SIGNATURE OF DECEASED [Faint text]		13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF PHYSICIAN [Faint text]		15. SIGNATURE OF CORONER [Faint text]		16. SIGNATURE OF JUDGE [Faint text]		17. SIGNATURE OF CLERK [Faint text]		18. SIGNATURE OF REGISTRAR [Faint text]		19. SIGNATURE OF [Faint text]		20. SIGNATURE OF [Faint text]		21. SIGNATURE OF [Faint text]		22. SIGNATURE OF [Faint text]		23. SIGNATURE OF [Faint text]		24. SIGNATURE OF [Faint text]		25. SIGNATURE OF [Faint text]		26. SIGNATURE OF [Faint text]		27. SIGNATURE OF [Faint text]		28. SIGNATURE OF [Faint text]		29. SIGNATURE OF [Faint text]		30. SIGNATURE OF [Faint text]		31. SIGNATURE OF [Faint text]		32. SIGNATURE OF [Faint text]		33. SIGNATURE OF [Faint text]		34. SIGNATURE OF [Faint text]		35. SIGNATURE OF [Faint text]		36. SIGNATURE OF [Faint text]		37. SIGNATURE OF [Faint text]		38. SIGNATURE OF [Faint text]		39. SIGNATURE OF [Faint text]		40. SIGNATURE OF [Faint text]		41. SIGNATURE OF [Faint text]		42. SIGNATURE OF [Faint text]		43. SIGNATURE OF [Faint text]		44. SIGNATURE OF [Faint text]		45. SIGNATURE OF [Faint text]		46. SIGNATURE OF [Faint text]		47. SIGNATURE OF [Faint text]		48. SIGNATURE OF [Faint text]		49. SIGNATURE OF [Faint text]		50. SIGNATURE OF [Faint text]		51. SIGNATURE OF [Faint text]		52. SIGNATURE OF [Faint text]		53. SIGNATURE OF [Faint text]		54. SIGNATURE OF [Faint text]		55. SIGNATURE OF [Faint text]		56. SIGNATURE OF [Faint text]		57. SIGNATURE OF [Faint text]		58. SIGNATURE OF [Faint text]		59. SIGNATURE OF [Faint text]		60. SIGNATURE OF [Faint text]		61. SIGNATURE OF [Faint text]		62. SIGNATURE OF [Faint text]		63. SIGNATURE OF [Faint text]		64. SIGNATURE OF [Faint text]		65. SIGNATURE OF [Faint text]		66. SIGNATURE OF [Faint text]		67. SIGNATURE OF [Faint text]		68. SIGNATURE OF [Faint text]		69. SIGNATURE OF [Faint text]		70. SIGNATURE OF [Faint text]		71. SIGNATURE OF [Faint text]		72. SIGNATURE OF [Faint text]		73. SIGNATURE OF [Faint text]		74. SIGNATURE OF [Faint text]		75. SIGNATURE OF [Faint text]		76. SIGNATURE OF [Faint text]		77. SIGNATURE OF [Faint text]		78. SIGNATURE OF [Faint text]		79. SIGNATURE OF [Faint text]		80. SIGNATURE OF [Faint text]		81. SIGNATURE OF [Faint text]		82. SIGNATURE OF [Faint text]		83. SIGNATURE OF [Faint text]		84. SIGNATURE OF [Faint text]		85. SIGNATURE OF [Faint text]		86. SIGNATURE OF [Faint text]		87. SIGNATURE OF [Faint text]		88. SIGNATURE OF [Faint text]		89. SIGNATURE OF [Faint text]		90. SIGNATURE OF [Faint text]		91. SIGNATURE OF [Faint text]		92. SIGNATURE OF [Faint text]		93. SIGNATURE OF [Faint text]		94. SIGNATURE OF [Faint text]		95. SIGNATURE OF [Faint text]		96. SIGNATURE OF [Faint text]		97. SIGNATURE OF [Faint text]		98. SIGNATURE OF [Faint text]		99. SIGNATURE OF [Faint text]		100. SIGNATURE OF [Faint text]	
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BUREAU V. 2

SEP 13 1957

RECEIVED

9279

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTO. CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>9 yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9 Helrey Ave</u>		d. STREET ADDRESS <u>9 Helrey Ave</u>	
3. NAME OF DECEASED (Type or print) <u>CAROLINA R. STEC</u>		4. DATE OF DEATH <u>9/7</u> 19 <u>57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/11/90</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>P</u>		14. MOTHER'S MAIDEN NAME <u>P</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>026 070 523</u>	
17. INFORMANT <u>Erene J. Stauffer</u>		Address <u>28</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATA UTERUS.</u> 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>0</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>0</u> 19 <u>57</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/16</u> , 19 <u>56</u> , to <u>SEPT. 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>SEPT. 7</u> , 19 <u>56</u> , and that death occurred at <u>1:00 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Lloyd Johnson</u> M.D.		ADDRESS (Street, city or town, state) <u>6348 FREDERICK ROAD CATONSVILLE</u> DATE SIGNED <u>MARYLAND.</u>	
PHYSICIAN'S NAME (Type) <u>S. LLOYD JOHNSON M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/11/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Macraft & Son</u> ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 11 '57</u>	24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 6 and 7 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

*item 18: G221 10/1/57

092883

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OWINGS MILLS		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Roxwood State Training School		d. STREET ADDRESS 2723 FAIRMOUNT AVE	
3. NAME OF DECEASED (Type or print) First Middle Last L ENFORD TYRONE STERRETT		4. DATE OF DEATH Month Day Year SEPT 21 1957	
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 18, 1949
9. AGE (In years last birthday) 7 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME John Robert Sterrett		14. MOTHER'S MAIDEN NAME Blanche Wilsonia Barrow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Mr + Mrs S. R. Sterrett 2723 Fairmount Ave Baltimore 23 Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia - 2 days * DUE TO (b) Schilders' Disease Positive diagnosis, 13/ds. DUE TO (c) of symptoms - 18 mos. - Dr. Harris 10-4-57 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 355x			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493x			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 17, 1957 , to Sept. 21, 1957 , that I last saw the deceased alive on Sept. 21, 1957 , and that death occurred at 7:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Roxwood St. Tr. School. DATE SIGNED Owings Mills, Maryland			
ACTUAL SIGNATURE Olive Beil Harris M.D.		PHYSICIAN'S NAME (Type) Owings Mills, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/24/1957	
22c. NAME OF CEMETERY OR CREMATORY Balto. National Cem. Balto. Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. K. Williams ADDRESS 3221 School St.		24. REC'D BY REGISTRAR DATE 9/24/57	
24b. REGISTRAR'S SIGNATURE Mary Gloneg			

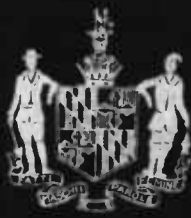
Mr. Geo. Christy
1905
0745

Shore
road
No. 1

BUREAU V. 3

SEP 25 1957

RECEIVED



Rosewood State Training School

Owings Mills, Maryland

Tel.: Hunter 6-5200

George C. Medaury, M.D.
Superintendent

Albert M. Clark
Administrative Ass't

VISITING DAYS: TUESDAY, THURSDAYS,
SUNDAYS AND HOLIDAYS
1:00 P. M. TO 4:00 P. M.

October 2, 1957

OCT 4 1957

State of Maryland
Department of Health
2411 N. Charles Street
Baltimore 18, Maryland

Re: Linford Tyrone Sterrett

Att: Mrs. Leidy

Gentlemen:

In reply to your letter of September 30, 1957 requesting definite information for Death Certificate of duration of illness on Linford Tyrone Sterrett, the immediate cause of death was listed as pneumonia - duration 2 days, and Schilder's Disease - positive diagnosis 10½ months, duration of symptoms 18 months. Therefore, in my opinion the certificate should read - pneumonia 2 days, Schilder's disease 18 months.

I regret any inconvenience this may have caused you and hope that the above information is sufficient.

Very truly yours,

Olive Reid Harris, M.D.
Olive Reid Harris, M.D.

orh/ps

9282 CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. NAME OF DECEASED
(Type or Print)SOPHIE M ~~STOKES~~ STOKES2. DATE
OF
DEATH

29 Sept 1957

3. PLACE OF DEATH

A. Baltimore City, Maryland Raphael Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE B. COUNTY

Georgia

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

00

UPPER FALLS, Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Atlanta

491-3

D. STREET ADDRESS (If rural, give location)

Georgian Terrace Hotels
Peachtree St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

June 12, 1882

9. AGE (In years
last birthday)

75

10. Under 1 Year
Months Days11. Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Greenville, S.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Mc Alister

14. MOTHER'S MAIDEN NAME

Virginia Earle

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. C. A. Stokes-80 Osner Dr.-Atlanta, Ga.

18.

420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Coronary Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

5 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Hypertensive Heart Disease
Coronary Arteriosclerosis

16 yrs

(C)

10 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☐

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22. I certify that (I) (this hospital) attended the deceased from 19.54 to 19.56, that (I) (we) last saw the deceased alive on March 19, 1956 and that death occurred at 6 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

ATTENDING PHYS.

MED. DIRECTOR ☐STAFF PHYS. ☐

M.D.

24 Sept 1957

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Removal

24B. DATE

9/30/57

24C. NAME OF CEMETERY OR CREMATORY

Christ Church Cemetery

24D. LOCATION (City, town, or county)

(State)

Greenville, South Carolina

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

10/1/57

Dr. Walter Hemmelt

Wm. J. Tichenor

1001 E. 1st St. Greenville, S.C.

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER DEATH.

BUREAU V. S.

OCT 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 6 and 7 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

0928340

9281

1. PLACE OF DEATH a. COUNTY Baltimore , Glen Arm MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Glen Arm Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arm, Md.				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS Glen Arm, Md.			
3. NAME OF DECEASED (Type or print) First Catherine Middle A. Last Stewart				4. DATE OF DEATH Month 9 Day 7 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/19/90	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Thomas Renner				14. MOTHER'S MAIDEN NAME Mary Gleason			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs Francis Phelps, Glen Arm, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: Primary Carcinoma of Liver 155X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 9 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 9, 1957 , to August 20, 1957 , that I last saw the deceased alive on August 20, 1957 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Milton Sherry M.D. 11 E. Chase St. 9/7/57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Milton Sherry							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/9/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook - Towson Inc. ADDRESS York Road Towson, Md.				24a. REC'D BY REGISTRAR DATE 9/10/57		24b. REGISTRAR'S SIGNATURE Dr. Walter H. H. H.	

BUREAU V. S.

SEP 11 1957

RECEIVED

9283

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 15yr8mth28dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cocekysville, Maryland			
f. STREET ADDRESS Adams Avenue				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lester Middle Storm Last Storm				4. DATE OF DEATH Month September Day 7 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 26, 1910	
9. AGE (In years last birthday) 47 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) storekeeper		10b. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William Storm		14. MOTHER'S MAIDEN NAME Emma Long			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic pericardial tamponade 162x DUE TO Cardiac metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Bronchogenic carcinoma, right (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 5, 19 57 , to Sept. 7, 19 57 , that I last saw the deceased alive on Sept. 7, 19 57 , and that death occurred at 10:15pM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 9-9-57			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				LOCATION (City, town, or county) (State) Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 10, 1957		22c. NAME OF CEMETERY OR CREMATORY Grace Methodist Cemetery		22d. LOCATION (City, town, or county) (State) Falls Rd., Cockeysville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John Basso				ADDRESS 4400 N. Towson		24a. REC'D BY REGISTRAR SEP 11 57	
				24b. REGISTRAR'S SIGNATURE Overman			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. S.

SEP 11 1957

RECEIVED

9284

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX MD.</u>				c. LENGTH OF STAY IN 1b <u>35 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT #13 Box 837 Pothay Fm. Rd.</u>				d. STREET ADDRESS <u>RT #13 Box 837 Pothay Fm. Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>THOMAS J. STOVER</u>				4. DATE OF DEATH <u>Sept. 3 1957</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-15-1883</u>	9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BETHLEHEM STEEL</u>		11. BIRTHPLACE (State or foreign country) <u>LOUIS CT. N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>JACOB STOVER</u>			
14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>216-10-4079</u>				17. INFORMANT <u>MRS. EVA B STOVER</u> Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> 2 YRS DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>490X LOBAR PNEUMONIA</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>JAN. 15, 1955</u> , to <u>SEPT. 3, 1957</u> , that I last saw the deceased alive on <u>AUG. 31, 1957</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph Miceli</u> M.D.				ADDRESS (Street, city or town, state) <u>108 S. TAYLOR AVE</u> DATE SIGNED <u>9/3/57</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI M.D.</u>				ESSEX 21 MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Miller Inc.</u> ADDRESS <u>-2431 E. Oliver St.</u>				24a. REC'D BY REGISTRAR <u>SEP 5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Kurland</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. No. 10

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
JAMES EARL RAY		Male		35		1922		Missouri		Missouri		Heart Disease		1968		Missouri		10:00 AM		J. Edgar Hoover		John Edgar Hoover	
Occupation		Education		Marital Status		Previous Illnesses		Previous Injuries		Previous Operations		Previous Hospitalizations		Previous Deaths		Previous Burials		Previous Cremations		Previous Dispositions		Previous Dispositions	
Attorney		Witness		Witness		Witness		Witness		Witness		Witness		Witness		Witness		Witness		Witness		Witness	

BUREAU V. 2

SEP 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9285

CERTIFICATE OF DEATH

09287 45

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDGEWATER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDGEWATER X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #1 EDGEWATER TERRACE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES F. STRECKFUS		4. DATE OF DEATH SEP 14 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/11/1901
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR: Months 5 Days 14 Hours 14 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK, STANDARD OIL (RET.)		11b. KIND OF BUSINESS OR INDUSTRY MD.	
12. CITIZEN OF WHAT COUNTRY? ALBA		13. FATHER'S NAME HENRY STRECKFUS	
14. MOTHER'S MAIDEN NAME BARBARA FEHR		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 214-01-4361		17. INFORMANT MILDRED STRECKFUS Address EDGEWATER TER.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary thrombosis (occlusion) DUE TO (b) Coronary insufficiency DUE TO (c) Arterio sclerotic		INTERVAL BETWEEN ONSET AND DEATH 1/2 hour 11 years 11 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes mellitus, mild		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-28 , 19 57 , to 8-12 , 19 57 , that I last saw the deceased alive on 8-12 , 19 57 , and that death occurred at 9:45 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Eugene C. Baumann		ADDRESS (Street, city or town, state) 413 Eastern Ave, Essex, Md.	
PHYSICIAN'S NAME (Type) Eugene C. Baumann		DATE SIGNED 9-14-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/17/57	
22c. NAME OF CEMETERY OR CREMATORIUM LOUDON PARK		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Clarence F. Hoffmann		ADDRESS (24) 3218 Hudson St.	
24a. REC'D BY REGISTRAR Edith Hurley		24b. REGISTRAR'S SIGNATURE Edith Hurley	
DATE SEP 18 1957			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

SEP 18 1957

RECEIVED

9286 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Baltimore, Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Nursing Home</u>				d. STREET ADDRESS <u>1 8323 Pleasant Plains Road</u>			
3. NAME OF DECEASED (Type or print) <u>Mrs. Katherine</u> First Middle <u>STROMMER</u>				4. DATE OF DEATH Month <u>September</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 21, 1882</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>? Stoffel</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-07-7267D</u>			
17. INFORMANT <u>STROMMER</u> Address <u>Mr. Paul J. Strommer, 8327 Pleasant Plai</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Amnigotrophic lateral sclerosis</u> <u>356.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4/15</u> , 19 <u>57</u> , to <u>9/8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/8</u> , 19 <u>57</u> , and that death occurred at <u>11:45 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward Gordon Grau</u> M.D.				ADDRESS (Street, city or town, state) <u>8523 Loch Raven Blvd</u> DATE SIGNED <u>9/9/57</u>			
PHYSICIAN'S NAME (Type) <u>Edward Gordon Grau</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/11/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road.</u>				24a. REC'D BY REGISTRAR <u>SEP 13 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Walter Gray</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

PLACE OF DEATH

SEX

AGE

CAUSE OF DEATH

DIAGNOSIS

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

DIAGNOSIS

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

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DATE OF DEATH

CAUSE OF DEATH

DIAGNOSIS

PLACE OF DEATH

DATE OF DEATH

BUREAU V. S.

SEP 13 1957

RECEIVED

9287 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 28 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland 3Y01-4	
f. STREET ADDRESS 1026 Barre Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Stanley Middle Sukstya Last Sukstya		4. DATE OF DEATH Month 9 Day 15 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 1, 1893
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) iron worker		12. KIND OF BUSINESS OR INDUSTRY Lithuania	
13. FATHER'S NAME Paul Sukstya		14. MOTHER'S MAIDEN NAME Anna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH unknown		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 9 , 19 57 , to Sep. 15 , 19 57 , that I last saw the deceased alive on September 15 , 19 57 , and that death occurred at 8:55A M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Bruno Radauskas M.D.		SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) BRUNO RADAUSKAS		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-18-57	
22c. NAME OF CEMETERY OR CREMATORY MOST HOLY REDEEMER		22d. LOCATION (City, town, or county) (State) BELOIR RD MD.	
23. FUNERAL DIRECTOR'S SIGNATURE C W Kochanowski		24a. REC'D BY REGISTRAR SEP 18 57	
ADDRESS 703 Mc Henry St #30		24b. REGISTRAR'S SIGNATURE W. J. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3287

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

<p>1. NAME OF DECEASED [Illegible Name]</p>		<p>2. SEX [Illegible]</p>	
<p>3. AGE [Illegible]</p>		<p>4. DATE OF BIRTH [Illegible]</p>	
<p>5. PLACE OF BIRTH [Illegible]</p>		<p>6. DATE OF DEATH [Illegible]</p>	
<p>7. TIME OF DEATH [Illegible]</p>		<p>8. PLACE OF DEATH [Illegible]</p>	
<p>9. CAUSE OF DEATH [Illegible]</p>		<p>10. MANNER OF DEATH [Illegible]</p>	
<p>11. SIGNATURE OF DECEASED [Illegible]</p>		<p>12. SIGNATURE OF WITNESS [Illegible]</p>	
<p>13. SIGNATURE OF PHYSICIAN [Illegible]</p>		<p>14. SIGNATURE OF CORONER [Illegible]</p>	
<p>15. SIGNATURE OF JUDGE [Illegible]</p>		<p>16. SIGNATURE OF CLERK [Illegible]</p>	

BUREAU V. 3

SEP 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09290

9288

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Lutherville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Broadway Road				d. STREET ADDRESS 1 Broadway Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ANNE Middle HOWELL Last TAYLOR				4. DATE OF DEATH Month Sept. Day 24 , Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1899		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME B. Frank Howell				14. MOTHER'S MAIDEN NAME Ruth G. Gandy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mr. J. Carey Taylor - Broadway Rd., Lutherville			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 18 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 4 , 19 57 to Sept 24 , 19 57 that I last saw the deceased alive on Sept 24 , 19 57 , and that death occurred at 1:50 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Jerome Miller				ADDRESS (Street, city or town, state) DATE SIGNED 2217 South Rd. Sept 25			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9/27/57		22c. NAME OF CEMETERY OR CREMATORY Green Mount Crem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Walker & Sons - Balto 17th				24a. REC'D BY REGISTRAR DATE SEP 27 '57		24b. REGISTRAR'S SIGNATURE W. H. Beach	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Page One

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1922	
5. PLACE OF BIRTH Jackson, Tennessee		6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White	
9. PLACE OF DEATH London, England		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. DATE OF DEATH June 6, 1968	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF REGISTRAR	

BUREAU V. S.

SEP 30 1957

RECEIVED

9289

CERTIFICATE OF DEATH

Reg. Dist. No.

09291 30
107

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata, Maryland 08x0.2			
d. STREET ADDRESS La Plata, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle D. Last Taylor				4. DATE OF DEATH Month September Day 16 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 1, 1881	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) plasterer				10b. KIND OF BUSINESS OR INDUSTRY consturction		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William W. Taylor				14. MOTHER'S MAIDEN NAME Rebecca E. Slack			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown				16. SOCIAL SECURITY NO. 486-12-9545A			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept. 11, 19 57 to Sept. 16, 19 57 , that I last saw the deceased alive on Sept. 16, 19 57 , and that death occurred at 4:00a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachslar M.D. SPRING GROVE STATE HOSPITAL 9-16-57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 9-20-57							
22c. NAME OF CEMETERY OR CREMATORY Jonestown							
22d. LOCATION (City, town, or county) (State) Jonestown							
23. FUNERAL DIRECTOR'S SIGNATURE Robert Mc Sept 20-1957							
24a. REC'D BY REGISTRAR DATE 9/19/57							
24b. REGISTRAR'S SIGNATURE A. St. Hedrich							

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		SEX Male	
DATE OF BIRTH May 19, 1928		PLACE OF BIRTH Jackson, Mississippi	
OCCUPATION None		MARITAL STATUS Single	
SOCIAL SECURITY NUMBER 44-3886100-1		RACE White	
DATE OF DEATH April 4, 1968		PLACE OF DEATH Memphis, Tennessee	
TIME OF DEATH 2:01 PM		CAUSE OF DEATH Gunshot wound	
MANNER OF DEATH Homicide		MEDICAL EXAMINER J. Edgar Hoover	
SIGNATURE OF DECEASED (None)		SIGNATURE OF MEDICAL EXAMINER (None)	
SIGNATURE OF NEXT OF KIN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

BUREAU V. S.

SEP 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09292

9172

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u> <u>3Y01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5506 Osage Avenue</u>		d. STREET ADDRESS <u>218 N. Hilton Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Florence</u> Last <u>Tewey</u>		4. DATE OF DEATH Month <u>September</u> Day <u>4</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1903</u>
9. AGE (In years lost birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Bernard F. Gallery</u>		14. MOTHER'S MAIDEN NAME <u>Anna Ross</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Leo M. Tewey, Sr. 218 N. Hilton Street</u>	
17. INFORMANT <u>Leo M. Tewey, Sr.</u>		Address <u>218 N. Hilton Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of breast with gen'l carcinomatosis</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 3, 1942</u> to <u>Sept 3, 1957</u> , that I last saw the deceased alive on <u>Sept 1, 1957</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Kennard Yaffe</u> M.D. <u>B3101 W Baltimore St</u>		DATE SIGNED <u>9/5/57</u>	
PHYSICIAN'S NAME (Type) <u>KENNARD YAFFE</u>		<u>Balto 29, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-7-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>		ADDRESS <u>4107 Wilkens Ave.</u>	
24a. REC'D BY REGISTRAR <u>SEP 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. L. M. Hubbard</u>	

SEP 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09293

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riderwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Penna Railroad Tracks 1/2 mile west of</u>		d. STREET ADDRESS <u>226 Linden Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>READ</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>September</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1884</u>
9. AGE (In years birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oliver Read</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Burehnel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Clarence Thomas, 226 Linden Ave., Towson, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing Injury to Skull</u> 802X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Sitting on RR track on 2nd side of track Train Rumbled Behind & Engine Struck Head of Deceased</u>	
20c. TIME OF INJURY Month, Day, Year <u>6:15 p.m. Sept 7 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Railroad track Riderwood, Balto Md</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 11, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Slate Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Delta, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons</u>		ADDRESS <u>Towson, Md.</u>	
24a. REC'D BY REGISTRAR <u>Sept. 10, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

REARVATD STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, date, time, place, and cause of death. The text is mirrored and difficult to read.

BUREAU V. S.

SEP 11 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

STATE OF MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09294

Reg. Dist. No.

35

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn.</u> b. COUNTY <u>Allegheny</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>		c. LENGTH OF STAY IN 1b <u>0</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Coatesville</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>FLIEZER TORRES</u>		4. DATE OF DEATH <u>Sept 28 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>30 ?</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple fractures & crushing</u> 816x DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>body injuries</u> (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>Sept 28 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at 11</u>		20f. (City or town) <u>Parkton</u> (County) <u>Balt.</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>A. M. France</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>10-14-57</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Chester L. Fulton</u>	
DATE <u>10/1/57</u>			

Fred Stal

Coatesville, Pa.

BUREAU V. S.

OCT 2 1957

RECEIVED

9292

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Randallstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Randallstown</u> X 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Holbrook Liberty Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Rachel Ellen Triplett</u> First Middle Last		4. DATE OF DEATH <u>Sept. 1</u> 19 <u>57</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 27, 1863</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Becraft</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Austin Boyd</u> Address <u>Randallstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 20, 1957</u> to <u>Sept 1, 1957</u> that I last saw the deceased alive on <u>Sept 1, 1957</u> , and that the death occurred at <u>1:20 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. E. Martin</u>		ADDRESS (Street, city or town, state) <u>Randallstown, Md</u> DATE SIGNED <u>9/2/57</u>	
PHYSICIAN'S NAME (Type) <u>W. E. Martin</u>		<u>RANDALLSTOWN, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-3-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ward's Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Luther H. Haight</u> ADDRESS <u>Lysiville, Md.</u>		24a. REC'D BY REGISTRAR <u>W. E. Martin</u> DATE <u>9/2/57</u>	24b. REGISTRAR'S SIGNATURE

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 5

SEP 4 1957

RECEIVED

ME

9293

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River				c. LENGTH OF STAY IN 1b 4 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hall Convalescent Home				d. STREET ADDRESS 6924 River Drive Road			
3. NAME OF DECEASED (Type or print) First Louis Middle Valerio Last Valerio				4. DATE OF DEATH Month September Day 16 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 26, 1873	
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min. 83		IF UNDER 24 HRS. Months 83 Days 83 Hours 83 Min. 83			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Spanish American				16. SOCIAL SECURITY NO.		17. INFORMANT Gilio Valerio Address 6924 River Drive Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Broncho pneumonia DUE TO (b) associated with Congestive Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X Heart failure DUE TO (c) Heart failure				INTERVAL BETWEEN ONSET AND DEATH 1 WEEK			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① Diabetes mellitus ② Rheumatoid Arthritis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Sept. 14, 19 57				20g. (County) Iron County, Wisconsin		20h. (State) 19 57	
21. I certify that I attended the deceased from Sept. 14, 19 57 , to Sept 15, 19 57 , that I last saw the deceased alive on Sept 16, 19 57 , and that death occurred at 6:30 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John E. Gannon				M.D.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 20, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Mary		22d. LOCATION (City, town, or county) (State) Iron County, Wisconsin	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc.				ADDRESS 403 S. Wolfe St.		24a. REC'D BY REGISTRAR Edith Farley	
24b. REGISTRAR'S SIGNATURE				DATE SEP 17 1957			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
SEX		RACE	
MARRIED		OCCUPATION	
EDUCATION		RELIGION	
BIRTH DATE		BIRTH PLACE	
MOTHER'S NAME		FATHER'S NAME	
MANNER OF DEATH		CAUSE OF DEATH	
PLACE OF BURIAL		DATE OF BURIAL	
SIGNATURE OF REGISTRAR		DATE OF REGISTRATION	

BUREAU V. 8

SEP 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0929741

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 53			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6731 Oak Ave.				d. STREET ADDRESS 6731 Oak Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE VANEK				4. DATE OF DEATH Month Day Year Sept. 12, 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT 2-1886	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Czechoslovakia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Plonk				14. MOTHER'S MAIDEN NAME Agnes Binousky			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO.		17. INFORMANT Address Alexander Wanek 6733 Oak Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO AS-C-V-Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AS-C-V-Disease (c) AS-C-V-Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M B Davis M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M B Davis M D				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 16, 1957		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Colgate, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.				24a. REC'D BY REGISTRAR 17 1957		24b. REGISTRAR'S SIGNATURE John Kelly	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
SEP 19 1957
BUREAU V. F.

9165

CERTIFICATE OF DEATH

Reg. Dist. No.

09298/1

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE MD b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN TB 27 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 120 VENTNOR TERRACE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES EMIL WEATHERLY		4. DATE OF DEATH Month Day Year 9/22/1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 29, 1904
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY STEEL MFG.	
11. BIRTHPLACE (State or foreign country) N. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOE WEATHERLY		14. MOTHER'S MAIDEN NAME EMMA GILBERT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-07-3963	
17. INFORMANT IRENE F. WEATHERLY		Address SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor DUE TO 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Lungs DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mo. 6 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 to 22 Sept, 1957 , that I last saw the deceased alive on 10 Sept, 1957 , and that death occurred at 6:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE B.W. Sollod		ADDRESS (Street, city or town, state) 2900 DUNRAN RD.	
PHYSICIAN'S NAME (Type) B.W. SOLLOD, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/25/57	22c. NAME OF CEMETERY OR CREMATORY CHURCH LAWN	22d. LOCATION (City, town or county) (State) BALTO. CO., MD
23. FUNERAL DIRECTOR'S SIGNATURE Walter Burke Bradley, Dundalk, Md.		24. REC'D BY REGISTRAR SEP 25 1957	
ADDRESS		24b. REGISTRAR'S SIGNATURE Jim Kelly	

SEP 25 1957

RECEIVED

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

1957

BALTIMORE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

BUREAU V. S.

SEP 17 1957

RECEIVED

9295

CERTIFICATE OF DEATH

09300 38

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Convalescent Home</u>		d. STREET ADDRESS <u>5704 The Alameda Blvd</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>RHODA</u> Middle <u>PENELOPE</u> Last <u>WHITEHORN</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 7, 1882</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Linwood, Neb.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Henry Wood</u>	
14. MOTHER'S MAIDEN NAME <u>Araminta Swan</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>104-09-3681H</u>		17. INFORMANT Address <u>Miss Catharine Whitehorn Same.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerosis, general</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>55</u> to <u>Sept. 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug. 31</u> , 19 <u>57</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Catharine Whitehorn</u> M.D.		ADDRESS (Street, city or town, state) <u>1041 St. Paul St, Baltimore, Md.</u>	
PHYSICIAN'S NAME (Type) <u>9/5/57</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>Sept 6, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Genkins & Son, Co.</u>		ADDRESS <u>4905 York Road</u>	24a. REC'D BY REGISTRAR DATE <u>SEP 6 1957</u>
		24b. REGISTRAR'S SIGNATURE <u>Hubel Gray</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is mostly blank with some faint, illegible markings.

BUREAU OF VITAL RECORDS

SEP 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5,6,7 FilmG221 10-7-57 et

CERTIFICATE OF DEATH

9166

09301

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore 22</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				c. LENGTH OF STAY IN 1b <u>55 yrs.</u> 53		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4065 Old North Pt. Rd.</u>				d. STREET ADDRESS <u>#1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>WIDRANSKY</u> Last				4. DATE OF DEATH Month <u>Sept</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 18. 1884</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel worker Beth Steel Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Beth Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Widransky</u>				14. MOTHER'S MAIDEN NAME <u>Mary Baca</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-07-5237</u>		17. INFORMANT Address <u>Cecelia Widransky (wife) #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno Carcinoma Esophagus</u> 150x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary edema</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 mo.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>July 13</u> , 19 <u>57</u> , to <u>Sept 29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept. 29</u> , 19 <u>57</u> , and that death occurred at <u>3 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis N. Hallin</u> M.D.				ADDRESS (Street, city or town, state) <u>6908 N. P+Rd.</u>		DATE SIGNED <u>9/29/57</u>	
PHYSICIAN'S NAME (Type) <u>Louis N. Tonnin</u> <u>Balto 19-</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Mary</u>		22d. LOCATION (City, town, or county) (State) <u>German Hill Rd. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Duda</u> ADDRESS <u>2829 Hudson St. 24, Md.</u>				24a. REC'D BY REGISTRAR <u>10/1/57</u>		24b. REGISTRAR'S SIGNATURE <u>John P. Kelly</u>	

BUREAU V. S.

OCT 2 1957

RECEIVED

9296

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 351 Savannah Rd.		d. STREET ADDRESS 351 Savannah Rd.	
3. NAME OF DECEASED (Type or print) First Frederick Middle C. Last Wilhelm		4. DATE OF DEATH Month Sept. Day 14 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1882
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min. 75	IF UNDER 24 HRS. Months 75 Days 75 Hours 75 Min. 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent Retired		10b. KIND OF BUSINESS OR INDUSTRY Life Insurance	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Wilhelm		14. MOTHER'S MAIDEN NAME Emma Wolf	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Charles C. Wilhelm		Address 351 Savannah Rd. (21)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease DUE TO (c) Sudden INTERVAL BETWEEN ONSET AND DEATH 5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Heart Block 2nd degree			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 , 19 57 , to Sept 15 , 19 57 , that I last saw the deceased alive on Sept 14 , 19 57 , and that death occurred at 9 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE G. M. Baumgardner		ADDRESS (Street, city or town, state) Balto 6 Md	
PHYSICIAN'S NAME (Type) G. M. Baumgardner		DATE SIGNED 9/16/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 18, 1957	
22c. NAME OF CEMETERY OR CREMATORY Baltimore		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR SEP 18 1957		24b. REGISTRAR'S SIGNATURE Edith Jenkins	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9297

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN lb 8mths26dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
				d. STREET ADDRESS 729 Newington Avenue			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ada Middle Lester Last Williams				4. DATE OF DEATH Month September Day 12 Year 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1867		9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME Mary Jane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis of coronary arteries DUE TO (c) Generalised arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH Several months several years many years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 26 , 19 56 to 9/12 , 19 57 , that I last saw the deceased alive on 9/12 , 19 57 , and that death occurred at 9:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Bruno Radauskas M.D.				SPRING GROVE STATE HOSPITAL			
PHYSICIAN'S NAME (Type) BRUNO RADAUSKAS				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-16-57		22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joe Forcel				ADDRESS 702 E North Ave		24a. REC'D BY REGISTRAR SEP 14 1957	
				24b. REGISTRAR'S SIGNATURE W. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 17 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 38

9298

1. PLACE OF DEATH o. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ind</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None 9710 Harford</u>		d. STREET ADDRESS <u>19710 Harford</u>	
3. NAME OF DECEASED (Type or print) <u>Rydia MAUD Wilson</u> First Middle Last		4. DATE OF DEATH <u>Sept 30 1957</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 1 1862</u> 9. AGE (In years lost birthday) <u>95</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. W. T.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Illinois</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Morris</u>		14. MOTHER'S MAIDEN NAME <u>Anna Oliver</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Joseph O. Wilson 9710 Harford Rd</u>	
17. INFORMANT <u>Joseph O. Wilson</u> Address <u>9710 Harford Rd</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dionthea Degeneration + Senility</u> 571.1 DUE TO <u>Age</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Age</u> (c) <u>Age</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>Sept</u> Day <u>28</u> Year <u>1957</u> Hour <u>5:57</u> a. m. <u>57</u> p. m. <u>57</u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Balto</u> (County) <u>Balto</u> (State) <u>MD</u>	
21. I certify that I attended the deceased from <u>Sept 28</u> to <u>Sept 30</u> , 19 <u>57</u> , and that death occurred at <u>7:00</u> M. from the causes and on the date stated above.		DATE SIGNED <u>Sept 28 1957</u>	
ACTUAL SIGNATURE <u>Frank T. Kadir, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>9605 Harford Rd</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T. KADIR, JR.</u>		<u>BALTO 14 MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT 3-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	22d. LOCATION (City, town, or county) <u>Balto Co</u> (State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. F. Evans & Son</u> ADDRESS <u>8802 Harford Rd</u>		24a. REC'D BY REGISTRAR <u>Dr. G. M. Bacon</u> DATE <u>Oct 1 1957</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957 3 OCT

RECEIVED

9299

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b <u>PIKESVILLE XO</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ARMACOST NURSING HOME</u>		d. STREET ADDRESS <u>STEVENSON RD.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>STELLA MIDDLETON WILSON</u>		4. DATE OF DEATH Month Day Year <u>SEPT. 30 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 17, 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>CHARLES WILMER MIDDLETON</u>		14. MOTHER'S MAIDEN NAME <u>EMILY POLK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS GAINES MACMILLAN</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension.</u> DUE TO <u>Cerebral metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> <u>3 mos.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 16, 1948</u> to <u>Sept 30, 1957</u> , that I last saw the deceased alive on <u>Sept 30, 1957</u> , and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Palmer F. Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>Pikesville 8.</u> DATE SIGNED <u>ml.</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT. 2, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. THOMAS</u>	22d. LOCATION (City, town, or county) (State) <u>GARRISON FOREST MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN O. MITCHELL & SONS</u>		ADDRESS <u>1900 EUTAW PLACE</u>	24a. REC'D BY REGISTRAR <u>DATE 10/4/57</u>
		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

FILE NO.

1. NAME OF DECEASED <i>JOHN J. BROWN</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>October 10, 1957</i>		5. TIME OF DEATH <i>10:15 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SIGNATURE OF PHYSICIAN <i>John J. Brown</i>	
16. SIGNATURE OF DECEASED <i>John J. Brown</i>		17. SIGNATURE OF WITNESSES <i>John J. Brown</i>		18. SIGNATURE OF DECEASED <i>John J. Brown</i>	

BUREAU V. S.

OCT 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09306

9300 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto.		3. NAME OF DECEASED (Type or print) VIRGINIA Appleton Wilson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION COLLEGE MANOR		d. STREET ADDRESS NORTHWOOD APTS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Sept 8 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 1881
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Balto Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J Appleton Wilson		14. MOTHER'S MAIDEN NAME MARY WADE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT MRS DAVID P BARRETT RUXTON MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pleural Effusion - Malignant? DUE TO Senile Menstrual Disorganization - vascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — (c) — INTERVAL BETWEEN ONSET AND DEATH 9 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1954 , to Sept 1957 , that I last saw the deceased alive on Sept 7 1957 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1101 St Paul St DATE SIGNED Valter A Baerjer			
ACTUAL SIGNATURE Valter A Baerjer M.D.		22a. NAME OF CEMETERY OR CREMATORY Green Mount	
22b. DATE THEREOF Sept 12/57		22c. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE H Jenkins ADDRESS Anslo 4905 York Rd		24a. REC'D BY REGISTRAR SEP 10 57 24b. REGISTRAR'S SIGNATURE Carlebach	

"In my opinion....'cancer of the pleura'.....

Dr.W.A.B. 9-13-57 ams

BUREAU V. S.

SEP 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09307

9301

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 409 Babikow Rd.</u>				d. STREET ADDRESS <u>Box 409 Babikow Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>C.</u> Last <u>Winterstein</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1889</u>		9. AGE (In years last birthday) yrs. <u>68</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adam Winterstein</u>				14. MOTHER'S MAIDEN NAME <u>Johanna Kern</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Matilda Winterstein Box 409 Babikow Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema: Cardiac Failure</u> DUE TO <u>Severe Anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Osteo Chondro Sarcoma</u> DUE TO (c) <u>undit</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>6-8 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>25 Sept</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>24 Sept</u> , 19 <u>57</u> , and that death occurred at <u>1:30</u> p.m., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John C. Hyle M.D.</u>				ADDRESS (Street, city or town, state) <u>7527 Belair Rd Balto, Md</u>			
PHYSICIAN'S NAME (Type) <u>JOHN C. Hyle</u>				DATE SIGNED <u>9-26-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 28, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Belair, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emmahn Funeral Home</u>				ADDRESS <u>7401 Belair Rd</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 30 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Thompson</u>			

BUREAU V. S.

SEP 30 1957

RECEIVED

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

ITEMS: 3, 8, 13, 14, 22b, 9, 57L
Film G 221.93-2

CERTIFICATE OF DEATH

10042
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 46yr3mth23dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 717 Poplar Grove St.			
3. NAME OF DECEASED (Type or print) ALSO KNOWN AS First AS Middle ISMA Last WOODEN William G. Wooden				4. DATE OF DEATH Month Sept. Day 30 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 22, 1875	
9. AGE (In years last birthday) 82		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) horse dealer		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME unknown George Wooden				14. MOTHER'S MAIDEN NAME unknown / Annie Scarborough			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 422.1 DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 30, 1957 , to Sept. 30, 1957 , that I last saw the deceased alive on Sept. 30, 1957 , and that death occurred 4:00 p.m. from the causes and on the date stated above. 4:00p. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Stella Wachsler				M.D. SPRING GROVE STATE HOSPITAL 9-30-57			
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
burial		Sept. 5, 1957		St. Giles		Woodensburg Md	
23. FUNERAL DIRECTOR'S SIGNATURE Stewart Hoffman				ADDRESS 108 W. North		24a. REC'D BY REGISTRAR DATE OCT 2 '57	
						24b. REGISTRAR'S SIGNATURE W. J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

2 OCT 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09308

9303

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 Vol-4	
f. STREET ADDRESS 642 So. Ellwood Ave.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle E. Last WRZASK		4. DATE OF DEATH Month September Day 5 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1898
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Cleaning & Pressing	
11. BIRTHPLACE (State or foreign country) Mielec, Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Wrzask		14. MOTHER'S MAIDEN NAME Anna Kcala	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. None	
17. INFORMANT Clin. Rec., Vet. Adm. Hosp. Ft. Howard, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE, LEFT DUE TO CEREBRAL ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO ESSENTIAL HYPERTENSION (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease			
19. INTERVAL BETWEEN ONSET AND DEATH 3 DAYS UNKNOWN UNKNOWN		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. VA Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 4, 1957 to September 5, 1957 and that death occurred at 6:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH Ft. Howard, Md DATE SIGNED 9/5/57 ACTUAL SIGNATURE Irving Freeman M.D. VAH Ft. Howard, Md 9/5/57 PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service VAH Ft. Howard, Md 9/5/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 9, 1957	
22c. NAME OF CEMETERY OR CREMATORY Holy Rosary		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., Eastern Ave. & Wolfe Sts. Balto. Md		24a. REC'D BY REGISTRAR DATE 9/6/57	
24b. REGISTRAR'S SIGNATURE Dorothy L. Farber			

SEP 9 1957

RECEIVED